MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01298

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: a a

City or town: annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place at death? 10 days

Hospital, institution, or street address where death occurred:
Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Riva
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Grace M. Austin

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Charles S. Austin

6.(c) If alive, give age: 69 years

7. Birth date of deceased (mo., day, yr.): April 19 1874

8. AGE: Years: 70 Months: 10 Days: If less than one day: hrs. min.

9. Birthplace: Newport RI
(Town, county, and state)

10. Usual occupation: Home Wife

11. Industry or business

FATHER
12. Name: Nelson Montague
13. Birthplace: RI

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Interment: Charles S. Austin

Address: Riva. Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 19/45 (month) (day) (year)

Cemetery or crematory

Location: Eudonia New York

18. Funeral director: B. L. Hopkins

Address: Annapolis Md

19. Feb. 19 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 18 1945, at 6 00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 8 1945 to Feb 18 1945 and that I last saw her alive on Feb 17 1945

	DURATION
Immediate cause of death: Cerebral hemorrhage	10 days
Due to: Arteriosclerosis cardio-vascular disease	?
Due to:	
Other conditions: anemia & Influenza	?

(Include pregnancy within 3 months of death)

Major findings at operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: S. Borsuck M.D.
M. D. or other

Address: Annapolis Md Date signed 2/19/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01299

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH

County: Anne Arundel County

City or town: rural R.F.D #3 nr Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town:

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Arundel Road

(If rural, give LOCATION)

R.F.D # 3

2.(a) If veteran, name war:

3.(a) FULL NAME Elsie Lucille Bassford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1941

8. AGE: Years: 3 | Months: 11 | Days: 16 | If less than one day: hrs. min.

9. Birthplace: A.A. Co. Md (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Thomas Bassford

13. Birthplace: A.A. Co. Md

MOTHER 14. Maiden name: Frances L. Wood

15. Birthplace: A.A. Co., Md

16. Informant: Mrs. Thomas Bassford

Address: R.7D #3, A.A. Co. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5 1945 (month) (day) (year)

Cemetery or crematory: Cedar Bluff

Location: Annapolis Md

18. Funeral director: John M. Taylor

Address: Annapolis, Md

19. Feb 5 1945 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death: Partial Cremation	
Due to: Burned in burning house.	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Allen Purvis DME M. D. or other

Address: Annapolis Md Date signed 2/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

61390

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Rural R7D #3 nr Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: R7D #3 Arundel Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME George Russell Bassford

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 3, 1944

8. AGE:

Years	Months	Days	If less than one day
	2	—	..... hrs. ..... min.

9. Birthplace A. A. Co, Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Thomas Bassford
13. Birthplace A. A. Co, Md

MOTHER
14. Maiden name Francis L. Wood
15. Birthplace A. A. Co, Md

16. Informant Mrs. Thomas Bassford
Address R7D #3 A. A. Co, Md

17. Burial Date thereof Feb 5 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md.

18. Funeral director John W. Taylor
Address Annapolis Md

19. Feb. 5 1945 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945, at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pastral Cremation	
Due to Drafted in a burning	
Due to burn	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Oliver Pusin DMD
(M. D. or other)
Address Annapolis Md Date signed 2/3/1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (180)

CERTIFICATE OF DEATH

01301 21
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Rural R.F.D.#3 nr. Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town R.F.D. #3 Arundel Road
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Thomas William Bassford **3.(b) Social Security Number**

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Jan. 18, 1942

8. AGE: Years	Months	Days	If less than one day
3	—	16	hrs. min.

9. Birthplace Anne Arundel Co., Md.
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name Thomas Bassford
13. Birthplace A.A. Co. Md

MOTHER 14. Maiden name Frances L. Wood
15. Birthplace A.A. Co. Md

16. Informant Mrs. Thomas Bassford
Address R.F.D.#3 A.A. Co. Md

17. Burial Date thereof Feb. 5, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md.

18. Funeral director John W. Taylor
Address Annapolis, Md.

19. Feb 5 1945 Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945 at 2 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Pectoral Cramps	
Due to Fractured rib &	
Due to Pneumonia Lobar	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John W. Purvis D.M.E.
M.D. or other
Address Annapolis Md. Date signed 2/3/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

01302

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Brooklyn - 25 -
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland. County: A. A.
City or town: Brooklyn - 25
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Patapsco Park
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Esther Mae Battle

3.(b) Social Security Number:

4. Sex: F.
5. Color or race: C.
6.(a) Single, married, widowed, or divorced: S.
6.(b) Name of husband or wife:
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): December - 9 - 1944

8. AGE: Years: | Months: 1 | Days: 25 | If less than one day ... hrs. ... min.

9. Birthplace: Baltimore. Md.
(Town, county, and state)
10. Usual occupation: None.
11. Industry or business

FATHER
12. Name: Robert Battle.
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Esther Smoothers
15. Birthplace: Maryland.

16. Informant: Robert Battle (father)
Address: Patapsco Park. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/6/45 (month) (day) (year)
Cemetery or crematory: Mt Calvary
Location: Brooklyn Md.
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley Ave.
19. 2/6 1945 (Date rec'd by registrar) M. H. Alba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1945, at 8:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Accidental Suffocation.	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 2/4/45
Where did injury occur? ~~Home~~ Patapsco Park - A. A. / Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Home.
Means of injury: Bed - (Negligence) Injured at work? No

23. SIGNATURE: Gustave H. Parker M.D. Acting medical examiner M. D. or other
Address: Glen Burnie, Md. Date signed: 2/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01303

Reg. Dist. No. 21

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 Days
Hospital, Institution, or street address where death occurred:
U.S.N.Hospital, Annapolis, Md.
How long in hospital or institution? 2 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3309 Forest Pk. Ave., Baltimore, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war: -

3.(a) FULL NAME: Louis Alan BLOCK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 6, 1940

8. AGE: Years	Months	Days	If less than one day
5	1	1	hrs. min.

9. Birthplace: Baltimore, Maryland (Town, county, and state)
10. Usual occupation: Child
11. Industry or business: -

FATHER
12. Name: Louis Harry BLOCK
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Grace Katherine Montague
15. Birthplace: Philadelphia, Pa.

16. Informant: U.S.N. Hospital, Annapolis, Md.
Address: Annapolis, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/12/45 (month) (day) (year)
Cemetery or crematory: Woodlawn
Location: Balto Md.

18. Funeral director: Joseph D. Sondheim,
Address: 1902 Eutaw Place, Baltimore, Md.

19. Feb. 8 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 7, 1945, at 11:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 6, 1945, to February 7, 1945 and that I last saw him alive on February 7, 1945

Immediate cause of death	DURATION
Chronic Tonsillitis	
Due to: RESPIRATORY FAILURE (STATUS LYMPHATICUS ?)	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Joseph U Sondheim, M.D. M. D. or other
Address: U.S.N.Hospital, Annapolis, Md. Date signed: 2-8-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Pub)

CERTIFICATE OF DEATH

61304

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elizabeth Boston

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: Jos Boston
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 7 1874

8. AGE:

Years	Months	Days	If less than one day
71	0	13	..... hrs. ..... min.

9. Birthplace: Balto Co. Md
(Town, county, and state)
10. Usual occupation: House work
11. Industry or business

FATHER
12. Name: Robert Boston
13. Birthplace: Unknown

MOTHER
14. Maiden name: Sharlit Boston
15. Birthplace: Unknown

16. Informant: Elias Boston
Address: Parole

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 25-45 (month) (day) (year)
Cemetery or crematory: Hope Celestial Cem.
Location: South River - Md.
18. Funeral director: G. A. Stanley & Son
Address: Galesville, Md
19. Feb. 23 1945 (Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/22/45 19..... at 5 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7/15/45 19..... to 2/22/45 19.....
and that I last saw h.. alive on 2/22/45 19.....

Immediate cause of death	DURATION
Cardiac Failure	3 yrs.
Due to. Mitral stenosis. Rheum. F.	
Duration 1. 3 years.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: Gordon H. Johnson M.d.
M. D. or other
Address 35 Northern Street Date signed 2/23/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01305

Reg. Diat. No. 22

1. PLACE OF DEATH:

County: Anne Arundel

City or town: District Training School, Laurel, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 years 6 months 14 days

Hospital, Institution, or street address where death occurred:
District Training School, Laurel, Md.

How long in hospital or institution? 16 years 6 months 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: ..... County: .....

City or town: Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1219 S. Capitol Street, S. W.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Naomi Briscoe

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife: .....

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): April 18, 1902

8. AGE: Years	Months	Days	If less than one day
42	9	16	..... hrs. ..... min.

9. Birthplace: Washington, D. C.
(Town, county, and state)

10. Usual occupation: Inmate, District Training School

11. Industry or business: Mental defective

FATHER — 12. Name: William Briscoe

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Emma Freeman

MOTHER — 15. Birthplace: Marshall Hall, Maryland

16. Informant: Records of District Training School

Address: Laurel, Maryland

17. Removal (Burial, cremation, or removal. Which?) Date thereof 2-4-45 (month) (day) (year)

Cemetery or crematory: Mt. Olive

Location: Bladensburg Road

18. Funeral director: Henry Ford Undertaking Co.

Address: 4th Street near M, S. W., D. C.

19. Feb 4 1945 (Date rec'd by registrar) Clara Kasbel Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 3 1945, at 2:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 1934, to February 3 1945 and that I last saw her alive on February 2 1945

Immediate cause of death	DURATION
acute cardiac failure	13 hours
Due to: Strangulated pediculated fibro-	
nyoma of uterus	36 hours
Due to:	
Other conditions: Pediculated Lypoma of rectum	3 years
Imbecile	life

(Include pregnancy within 3 months of death)

Major findings of operations: No Operation

Date of op.: .....

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: James Edwards M.D.
M. D. or other

Address: District Training School Date signed 2-3-45
Laurel, Maryland

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

01306

Reg. Diat. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct one is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a—a—

City or town: Waterbury (If outside city or town limits, write RURAL and give nearest town) Md.

How long in above place of death? 6 6 Years

Hospital, institution, or street address where death occurred: No

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a~a—

City or town: Waterbury — Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. — Rural
(If rural, give LOCATION)

2.(a) If veteran, name war: No

3. (a) FULL NAME: Thomas Brooks.

3. (b) Social Security Number: No

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col-	Widower

6.(b) Name of husband or wife: Ethel Brooks

6.(c) If alive, give age: Dead. years

7. Birth date of deceased (mo., day, yr.): Oct. 8, 1878

8. AGE: Years	Months	Days	If less than one day
66	4	8	— hrs. — min.

9. Birthplace: Waterbury a-a- Md
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: —

FATHER — 12. Name: George Brooks

FATHER — 13. Birthplace: Waterbury Md.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknow

16. Informant: Thomas Brooks Jr.

Address: Waterbury Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2. 20 1945 (month) (day) (year)

Cemetery or crematory: Mt Tabor Cemt.

Location: Chesterfield Md

18. Funeral director: E. M. B. Parker

Address: 47 Washington St.

19. Feb 20 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 16, 1945 at 6 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 11, 1945, to Feb 16, 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Cardiac Failure	2 mo
Due to Mitral insufficiency, cause	
Duration: Some years	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Theodore N. Johnson md M. D. or other

Address: 35 Northwest State Date signed: 2/14/45

Dr Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (469)

CERTIFICATE OF DEATH

61307

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 yrs., 6 mos., 19 days

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 33 yrs., 6 mos., 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown

(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: Brown - Clarence

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1881

8. AGE: Years	Months	Days	If less than one day
64	?	?	---- hrs. ---- min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Waiter

11. Industry or business: ------

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. (Burial, cremation, or removal. Which?) burial Date thereof 2-12-45 (month) (day) (year)

Cemetery or crematory: Hollydale

Location: Crownsville Md

18. Funeral director: [illegible]

Address

19. (Date rec'd by registrar) Feb 13 1945 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1945 at 7:00P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from July 21 1911 to Feb. 10 1945 and that I last saw him alive on February 10 1945

Immediate cause of death	DURATION
Cancer of pancreas with Metastasis in the liver	About 6 mos.
Due to: -------	
Due to: -------	
Other conditions: General Arteriosclerosis	unknown

(Include pregnancy within 3 months of death)

Major findings of operations: ---------- Date of op. ------

Autopsy results: Cancer of pancreas with Metastasis in the liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of -----

Where did injury occur? ---------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ------

Means of injury ---------- Injured at work? -----

23. SIGNATURE: [signature] M. D. or other

Address: Crownsville, Maryland Date signed 2/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01308

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

1. PLACE OF DEATH:
County: Ann Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A.A.
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 108 Washington St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Richard Brown

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Perdella Brown
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 10, 1880.

8. AGE: Years	Months	Days	If less than one day
65	4	26	hrs. min.

9. Birthplace: Annapolis Md.
(Town, county, and state)
10. Usual occupation: Waiter
11. Industry or business
FATHER 12. Name: Unknown
13. Birthplace
MOTHER 14. Maiden name: Eliza Burnette
15. Birthplace: Md.
16. Informant: Perdella Brown
Address: 108 Washington St. Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 8, 1945 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis, Md.
18. Funeral director: J.B.Johnson
Address: Annapolis, Md.
19. Feb. 8 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 5, 1945, at 7:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1, 1945, to Feb 5, 1945 and that I last saw him alive on Feb 5, 1945

Immediate cause of death	DURATION
Cerebro Arter Sclerosis	2 days.
Due to	
Due to	
Other conditions Diabetes Mellitus	One year

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. L. Richardson M. D. or other
Address: Annapolis, Md. Date signed: 2/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01309

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 months, 22 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 6 months, 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1037 North Eutaw Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3. (a) FULL NAME: CARR - NORMAN

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

8.(b) Name of husband or wife: Ethelia Carr
8.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years	Months	Days	If less than one day
34	unknown		--- hrs. -- min.

9. Birthplace: South Carolina (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: unknown

FATHER
12. Name: Cal Carr
13. Birthplace: South Carolina

MOTHER
14. Maiden name: Annie Swinton
15. Birthplace: South Carolina

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-1-45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel Co.
18. Funeral director: Adolphus Halstead
Address: 918 Druid Hill Ave

19. 3/2/45 (Date rec'd by registrar) E. F. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 26 19 45 at 9:10A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 4 19 44 to Feb. 26 19 45
and that I last saw him alive on February 26 19 45

Immediate cause of death	DURATION
General Paresis	known to us since 8/4/44
Due to: ------	
Due to: ------	
Other conditions: ---------	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.: -----
Autopsy results: ---------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ------
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---------
Means of injury: ---- Injured at work? ------

23. SIGNATURE: Herbert A. Saunders M. D. or other
Address: Crownsville, Maryland Date signed: 2/26/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

EVIDENCE for change of spelling of surname shown on Film G92 3-2-45. L

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

CERTIFICATE OF DEATH

(1310

Reg. Dist. No. 21

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1307 Poplar Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Joseph Cizak CIZEK

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Johanna Cizak
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 5th 1872

8. AGE: Years	Months	Days	If less than one day
73	9	9	hrs. min.

9. Birthplace: Bohemia (Town, county, and state)
10. Usual occupation: Tailor Ret.
11. Industry or business

FATHER
12. Name: Joseph Cizak
13. Birthplace: Bohemia

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Johanna Cizak
Address: Annapolis Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 17th 1945 (month) (day) (year)
Cemetery or crematory: Druid Ridge
Location: Baltimore Md.

18. Funeral director: Wm J. Fechner. Inc Co
Address: Baltimore Md.

19. Feb 15 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1945, at 7 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Feb 14 1945
and that I last saw h. in alive on Feb 14 1945

Immediate cause of death	DURATION
Myocardial chr.	Unknown
Due to: Myocardial Insufficiency	
Due to:	
Other conditions: Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operation:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Bond M. D. or other
Address: Annapolis Md Date signed: 2-14-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01311

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs., 11 mos., 1 day
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 yrs, 11 mos, 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Camp Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ------

3. (a) FULL NAME: COATES - MINNIE

3. (b) Social Security Number: --------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: -------
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1911

8. AGE: Years	Months	Days	If less than one day
34	---	---	-- hrs. -- Min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ------

FATHER
12. Name: Asbury Howard
13. Birthplace: Maryland

MOTHER
14. Maiden name: Alberta Butler
15. Birthplace: Maryland

16. Interment: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal? Which?) Date thereof: Feb. 9, 1945 (month) (day) (year)
Cemetery or crematory: Hopefield Chapel ~~Brewer Hill~~ Cemetery
Location: Edgewater ~~Annapolis~~, Maryland
18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland

19. Feb. 7 1945 (Date rec'd by registrar) E. F. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5, 1945, at 10:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 4 1940 to Feb. 5 1945 and that I last saw her alive on February 5 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs. plus
Due to: ---------	
Due to: ---------	
Other conditions: Chorea - Huntington plus Syphilis (Include pregnancy within 3 months of death)	5 yrs.

Major findings of operations: --------
Date of op.: -----
Autopsy results: --------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------ Date of: ----
Where did injury occur? ------ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): --------
Means of injury: ------ Injured at work? -----

23. SIGNATURE: Harold Hancock M. D. or other
Address: Crownsville, Maryland Date signed: 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The cor... is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

01312

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

Reg. Diat. No. 28

(M) MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs., 3 mos., 8 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 10 yrs., 3 mos., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: St. Mary's

City or town: Leonardtown
(If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: unknown

3.(a) FULL NAME: COATES - ROBERT W.

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	separated

6.(b) Name of husband or wife: unknown

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1898

8. AGE: Years	Months	Days	If less than one day
47	---	---	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Farm Hand

11. Industry or business: ---

FATHER — 12. Name: George Coates
13. Birthplace: Maryland

MOTHER — 14. Maiden name: Etta Stevens
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2/26/45 (month) (day) (year)

Cemetery or crematory: Mt. Calvary cem.

Location: A. A. County

18. Funeral director: Edw. Lynch & Halstead

Address: 918 Druid Hill Ave., Balto., Md.

19. 2/26/45 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17 19 45 at 8:45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 9 19 34 to February 17 19 45 and that I last saw him alive on February 17 19 45

Immediate cause of death	DURATION
Chronic Myocarditis	about two mont
Due to ---	
Due to ---	
Other conditions: Dementia Praecox - Paranoid Type (Include pregnancy within 3 months of death)	Known to us since 11/16/3

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ---

Accident, suicide, or homicide: --- Date of ---

Where did injury occur? --- (City or town) --- (County) --- (State)

Injured at home, farm, industry, public place (where?): ---

Means of injury: --- Injured at work? ---

23. SIGNATURE: Hilton J. Armroyd M. D. or other

Address: Crownsville, Maryland Date signed 2/17/45

4314

Coates - Robert W.
St. Mary's County
Admitted - November 9, 1934

Died - February 17, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (30-C)

CERTIFICATE OF DEATH

01313

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 month, 3 days

Hospital, institution, or street address where death occurred:
Crownsville State Hospital

How long in hospital or institution? 1 month, 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Dorchester

City or town: Lakewood
(If outside city or town limits, write RURAL and give nearest town)

Street No. unknown
(If rural, give LOCATION)

2.(a) If veteran, name war: no

3.(a) FULL NAME COLEMAN - FRANK

3.(b) Social Security Number unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---

6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE: Years	Months	Days	If less than one day
39	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Lynsbony)
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: Joe Coleman
13. Birthplace: Maryland

MOTHER
14. Maiden name: Sarah ?
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. burial (Burial, cremation, or removal. Which?) Date thereof 2-26-45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville Md

19. Funeral director: Supt. Hospital

Address

19. Feb 26 1945 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23 19 45 at 4:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 3 19 45 to Feb. 23 19 45

and that I last saw him alive on February 23 19 45

Immediate cause of death	DURATION
General Paresis	known to us since 1/17/45
Due to: 0	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. ---

Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? --- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---

Means of injury --- injured at work? ---

23. SIGNATURE: Harry V. Armbrust, M. D. or other

Address: Crownsville, Maryland Date signed 2/23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for addition to cause of death on Film G 93, March 21, 1945.

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

01314

CERTIFICATE OF DEATH

Reg. Dist. No. 26

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Churchton (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Md County: A. A.
City or town: Churchton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Louis Reginald Crandell
3.(b) Social Security Number

4. Sex: M.
5. Color or race: W.
6.(a) Single, married, widowed, or divorced:
6.(b) Name of husband or wife: Grace Crandell
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Oct 16th – 1906

8. AGE: Years 38, Months 3, Days 18. If less than one day ... hrs. ... min.

9. Birthplace: Churchton Md (Town, county, and state)
10. Usual occupation: Farmer – Dairy
11. Industry or business:

FATHER
12. Name: Louis A. Crandell
13. Birthplace: Churchton

MOTHER
14. Maiden name: Elizabeth Dawson
15. Birthplace: Mayo Md

16. Informant: Bennett J. Crandell
Address: Churchton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 6 1945 (month) (day) (year)
Cemetery or crematory: Quaker Cem.
Location: Galesville Md

18. Funeral director: F. A. Hardesty & Son
Address: Galesville Md

19. Feb. 5 1945 (Date rec'd by registrar) I. B. Dent, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1945, at 3 a M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19 ..., to ... 19 ...
and that I last saw h... alive on ... 19 ...

Immediate cause of death: Compound fracture of skull with basal fracture.
Due to: Fracture of neck
Due to:
Other conditions: Automobile accident (Include pregnancy within 3 months of death)
DURATION: Rapidly

Major findings of operations: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Feb 4 1945
Where did injury occur? Churchton Road, A. A. Co., Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Churchton Road
Means of injury: Car ran off road, thrown driver from vehicle fracturing skull and breaking neck. Injured at work?

23. SIGNATURE: Oliver Purnell D. M. E. M. D. or other
Address: Annapolis Md Date signed: 2/5/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

01315

CERTIFICATE OF DEATH

Reg. Diat. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Shadmoor R.F.D # 2 Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Since birth
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Shadmoor R.F.D # 2 Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Charles Cromwell Jr.

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

6.(b) Name of husband or wife: —
6.(c) If wife, give age ... years
7. Birth date of deceased (mo., day, yr.): October 4th 1944

8. AGE: Years | Months: 4 | Days | If less than one day: ... hrs. ... min.

9. Birthplace: Shadmoor Anne Co Md
(Town, county, and state)
10. Usual occupation: none
11. Industry or business: —

FATHER
12. Name: Charles Cromwell
13. Birthplace: Shadmoor Anne Co Md

MOTHER
14. Maiden name: Lillian Hunt
15. Birthplace: Anne Co Md R F D # 2 Annapolis

16. Informant: Lillian Hunt (mother)
Address: Shadmoor Anne Co Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 6 1945 (month) (day) (year)
Cemetery or crematory: Broad Neck
Location: St. Margarettes
18. Funeral director: J. B. Johnson
Address: 34 Lafayette Ave
19. Feb. 5 45 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3rd 1945, at 4:45 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Pneumonia	4 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Oliver Pearce DMD
M. D. or other
Address: Annapolis Md Date signed 2/3/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

01316 P

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Patapsco Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 54
Hospital, institution, or street address where death occurred:
How long in hospital or institution? V

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: A A. Md
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Hoffmans Elizath Rte.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Henry Dawson Dawson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Col	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 1894

8. AGE: Years	Months	Days	If less than one day
51			hrs. min.

9. Birthplace: Ga (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: V
FATHER 12. Name: James Dawson
13. Birthplace: Ga
MOTHER 14. Maiden name: Mary Jones
15. Birthplace: Ga
16. Informant: Arthur Sparrow
Address: 921 Boyd Street
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/17/45 (month) (day) (year)
Cemetery or crematory: A.A. Co Md Mt Calvary
Location: A.A. Co. Md
18. Funeral director: Sarah L. Brown Dow
Address: 1089 Montgomery Street
19. 2/17 1945 (Date rec'd by registrar) C.W. Hedrick per MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 1945, at 11 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 7 1945, to Feb. 14 1945
and that I last saw him alive on Feb. 14 1945

Immediate cause of death	DURATION
Cardio-Vascular Disease	4 mos.
Due to	
Due to	
Other conditions: Arterio-sclerosis	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Chas. L. Sale M.D.
M.D. or other
Address: Linthicum Date signed 2-14-45

M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd. V.S.
2/12/65

Evidence for change of age of deceased is shown on FILM No G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01317

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel County
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All his life
Hospital, institution, or street address where death occurred: 51 Fleet St. Annapolis Md.
How long in hospital or institution? ××××××××××××××

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 51 Fleet St.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles Dennis

3. (b) Social Security Number: 218-14-3446

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored	Married

6.(b) Name of husband or wife: Sara Louise Dennis
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): March 31, 1873

8. AGE: Years	Months	Days	If less than one day
~~72~~ 71 ~~72~~			....hrs. ....min.

9. Birthplace: Annapolis Md. A. A. Co. (Town, county, and state)
10. Usual occupation: laborer
11. Industry or business: None

FATHER
12. Name: Edward Dennis
13. Birthplace: Eastern Shore Md.

MOTHER
14. Maiden name: Mary Glee
15. Birthplace: EasternShore Md.

16. Informant: Mrs Sara L. Dennis
Address: 51 Fleet St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/8/45 (month) (day) (year)
Cemetery or crematory: Breur Hill Cemetery
Location: West St. Extd.

18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Feb. 8 1945 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 4 1945, at 10 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 25, 1945, to Feb 4 1945
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular Disease	2 wk.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...
Autopsy results: ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE: Theodore N. Johnson M.D. M. D. or other
Address: 35 Northwest St. Date signed 2/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95)

CERTIFICATE OF DEATH

61318

Reg. Diat. No. 21

1. PLACE OF DEATH:

County A. Ar.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

32 Pleasant

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 32 Pleasant St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Louise Dogan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem.	Colored	widow

6.(b) Name of husband or wife Vane Dogan

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1892

8. AGE: Years	Months	Days	If less than one day
52	5		..... hrs. ..... min.

9. Birthplace Annapolis (Town, county, and state)

10. Usual occupation Domestic

11. Industry or business

FATHER 12. Name Charles Johnson

13. Birthplace A. A.

MOTHER 14. Maiden name Matilda Henson

15. Birthplace Md.

16. Informant Elizabeth Watkins

Address 32 Pleasant St

17. Burial (Burial, cremation, or removal) Which?) Date thereof Feb 26/45 (month) (day) (year)

Cemetery or crematory Brewer Hall

Location Annapolis

18. Funeral director J B Johnson

Address Annapolis

19. Feb 26 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION 15

20. DATE OF DEATH Feb. 21 1945, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated, [redacted] Post mortem Examination Feby. 21 1945

Immediate cause of death	DURATION
Acute Dilatation of Heart	duration
Due to	
Cardiac asthma	12 yrs
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE John A. Cuffy M. D. Deputy Medical Examiner

Address Annapolis Md. Date signed 2/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01319

CERTIFICATE OF DEATH

Reg. Dist. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

I

VS A15

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Sr. Rest Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A.
City or town: Parole
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: George W. Dorsey

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	colored	widower

6.(b) Name of husband or wife: Della Dorsey
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb. 20 1881

8. AGE: Years	Months	Days	If less than one day
63	11		hrs. min.

9. Birthplace: Sr. River (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: James W. Dorsey
13. Birthplace: Md.
MOTHER 14. Maiden name: Rachiel Tydings
15. Birthplace: Md.
16. Informant: William Dorsey
Address: Parole, Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Feb. 5 1945 (month) (day) (year)
Cemetery or crematory: Brewer Hill
Location: Annapolis
18. Funeral director: J. B. Johnson
Address: Annapolis
19. Feb. 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 2 1945, at 2:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 31 1945 to Feb. 2, 1945 and that I last saw h... alive on Feb 2, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Arterial Hypertension	1 year
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: K. L. Le Gardeur M.D. M. D. or other
Address: Parole, Md. Date signed: 2/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01320

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 17 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1200 Waldo Street
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: FIELDS - SADIE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

6.(b) Name of husband or wife: Norman Fields
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1906

8. AGE: Years	Months	Days	If less than one day
39	unk.	unk.	--- hrs. --- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof Feb. 27, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County

18. Funeral director: Mrs. Ida Bailey
Address: 1421 Jefferson St., Balto., Md.

19. 2/24/45 (Date rec'd by registrar) E F Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23, 1945, at 4:00P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 6, 1944, to February 23, 1945 and that I last saw her alive on February 23, 1945

Immediate cause of death	DURATION
General Paresis	3½ mos.
Due to ---	
Due to ---	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: [signature] M. D. or other
Address: Crownsville, Maryland Date signed: 2/23/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
FEB 26 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61321

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 Hyde Alley
(If rural give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John H. Frantom

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 4, 1883

8. AGE: Years	Months	Days	If less than one day
61	3	29	hrs. min.

9. Birthplace Annapolis, Md
(Town, county, and state)
10. Usual occupation waterman
11. Industry or business
FATHER 12. Name William H. Frantom
13. Birthplace Baltimore, Md
MOTHER 14. Maiden name Laura V. Frazier
15. Birthplace Annapolis, Md
16. Informant Mrs. Lillie M. Fairclough
Address Silver Springs, Md
17. Burial Date thereof Feb 7, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis Md
18. Funeral director John M. Taylor
Address Annapolis Md.
19. Feb 5 1945
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945 at 6 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
19 to 19
and that I last saw h alive on 19

Immediate cause of death	DURATION
Due to Coronary Occlusion	Hours
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Oliver Parran DME
M. D. or other
Address Annapolis Md Date signed 2/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

61322

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No. 100 McKendree Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Myrt Elmer Fullerton

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Mamie R. Fullerton
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 19, 1880

8. AGE: Years 64 | Months 9 | Days 25 | If less than one day ..... hrs. ..... min.

9. Birthplace Ohio (Town, county, and state)
10. Usual occupation ret. instructor of fire control
11. Industry or business at U.S.N.A.
12. Name of father William Fullerton
13. Birthplace of father Ohio
14. Maiden name of mother Rebecca Hessler
15. Birthplace of mother Ohio
16. Informant Mrs. Mamie R. Fullerton
Address 100 McKendree Ave, Annapolis
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 15 1945 (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md
18. Funeral director John M Taylor
Address Annapolis, Maryland
19. Feb 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 13 1945 at 12 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 1945 to Feb 13 1945 and that I last saw him alive on Feb 13 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE George C Bosse M. D. or other
Address Annapolis Md Date signed 2-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01323

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Anne Arundel
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs
Hospital, institution, or street address where death occurred:
2nd Ave & Morgan Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Anne Arundel
City or town Brooklyn Park
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2nd Ave & Morgan Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Adolph G. Gatzke

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife Amelia Gatzke
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.) May 14 - 1867

8. AGE: Years	Months	Days	If less than one day
77	8	20	.... hrs. .... min.

9. Birthplace Germany
(Town, county, and state)
10. Usual occupation Retired
11. Industry or business B. O. Laborer.
FATHER 12. Name Unknown
13. Birthplace Germany.
MOTHER 14. Maiden name Unknown
15. Birthplace Germany.
16. Informant Helen A. Wideman
Address 1624 Harford Ave.
17. Burial Date thereof Feb 6, 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Hill
Location A. A. Co. Md
18. Funeral director Mr. Mrs. John W. Teufel & Son
Address 801 W. Fayette St.
19. February 5 1944 Ida M. Whitson
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945, at 11.30 a M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan - 1945, to Feb 3, 1945
and that I last saw h....... alive on .... 19.......

Immediate cause of death	DURATION
Coronary Thrombosis	1 day
Due to Arteriosclerosis	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide .... Date of ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul Schenfeld M. D. or other
Address 801 Aisquith St Date signed 2/3/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

01324

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For oewborn infants give residence of mother)
State: Maryland County: Prince Goerge's
City or town: Croom Station
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3.(a) FULL NAME: GORDON - JOHN FRANCIS

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1869

8. AGE: Years	Months	Days	If less than one day
76	unk.	unk	---- hrs. ---- min.

9. Birthplace: unknown (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 28, 1945 (month) (day) (year)
Cemetery or crematory: St. Simon
Location: Croom, Maryland

18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland

19. 2/23/45 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 22 19 45 at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from February 9 19 45 to Feb. 22 19 45 and that I last saw him alive on February 22 19 45

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 2/9/45.
Due to: ----	
Due to: ----	
Other conditions: Senile Psychosis	known to us since 2/9/45.

(Include pregnancy within 3 months of death)

Major findings of operations: ----
Date of op.: ----
Autopsy results: ----
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ---- Date of: ----
Where did injury occur? ---- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ----
Means of injury: ---- Injured at work? ----

23. SIGNATURE: Edward T. Gordon M. D. or other
Address: Crownsville, Maryland Date signed 2/22/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

EVIDENCE for change of age shown on Film G92 2-16-45; also affida it, Film G92 2-14.

Form 99 Green

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01325

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 months, 23 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 months, 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: -------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 908 Jordan Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3.(a) FULL NAME
GRIFFIN - ROBERT or ROBERT Rawson

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Evelyn Griffin (common-law wife) 6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): /1895//?/ April 10 1904

8. AGE: Years 59/?40 Months 9 Days 28 If less than one day: ----- hrs. ----- min.

9. Birthplace: Texas (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 14, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel County

18. Funeral director: Robert L. Young
Address: 804 N. Caroline St., Balto., Md.

19. 2/14/45 (Date received by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 8 1945, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 15 1944, to February 8 1945 and that I last saw him alive on February 8 1945

Immediate cause of death	DURATION
General Paresis	known to us since 9/15/44
Due to: -------	
Due to: -------	
Other conditions -------	

(Include pregnancy within 3 months of death)

Major findings of operations: -------
Date of op.: -------
Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -------
Where did injury occur? ------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ------- injured at work? -------

23. SIGNATURE: Herbert Rinehardt M. D. or other
Address: Crownsville, Maryland Date signed: 2/8/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

OVER

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

01326

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH

County: A A

City or town: Glenburnie

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A A

City or town: Glenburnie Md

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Annapolis Rd

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME Dorothy Sharon Gunther

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 8 - 45

8. AGE: Years | Months | Days | If less than one day: hrs. min.

Years: | Months: | Days: 1 0 | hrs. | min.

9. Birthplace: Glenburnie Md

(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: Wm Gunther

FATHER — 13. Birthplace: Pilley Md

MOTHER — 14. Maiden name: Dorothy Lamb

MOTHER — 15. Birthplace: Glenburnie Md.

16. Informant: Wm Gunther

Address: Glenburnie Md.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Feb. 19 - 1945 (month) (day) (year)

Cemetery or crematory: Meadow Ridge Memo.

Location: Washington Blvd. A.A. Co. Md

18. Funeral director: Thomas W Singleton

Address: Glen Burnie, Md.

19. Feb. 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 - 45 1130 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 12 - 45 19 to Feb 17 - 45 19

and that I last saw h alive on Feb 16 - 45 19

Immediate cause of death	DURATION
Acute Bronchopneumonia	1 day
Due to	
Due to	2 hours
Other conditions Contributing Factors	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. L. Sparks M. D. or other

Address: Glenburnie Md Date signed: Feb 18 - 45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01327

Reg. Diat. No. 21

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? All his Life

Hospital, institution, or street address where death occurred:
36 Calvert St.

How long in hospital or institution? ********** ******

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 36 Calvert St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3. (a) FULL NAME: Charles E. Hall

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	Colored	Widower

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: ******

7. Birth date of deceased (mo., day, yr.): July 7, 1875

8. AGE: Years	Months	Days	If less than one day
70 69-70			....hrs. ....min.

9. Birthplace: Annapolis Md.
(Town, county, and state)

10. Usual occupation: Cabinet Maker

11. Industry or business: None

FATHER
12. Name: John Wessley Hall
13. Birthplace: Anne Arundel Co. Md.

MOTHER
14. Maiden name: Rebecca Hemsley
15. Birthplace: Annapolis Md.

16. Informant: Mrs Carrie Hall
Address: 36 Calvert Street Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/ 5/ 45 (month) (day) (year)

Cemetery or crematory: Breur Hill Cemetery

Location: West St. Ext.

18. Funeral director: Ethel L. Hicks

Address: 45 Northwest St. Annapolis Md.

19. Feb. 5 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/2 19 45 at 2 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12/15 19 44 to 2/2 19 45 and that I last saw h... alive on 2/2/45 19....

Immediate cause of death	DURATION
Hypertensive Cardio-Vascular	
Due to: Disease	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op. ....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: .... Date of ....

Where did injury occur? .... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ....

Means of injury .... injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: 35 Northwest St. Date signed 2/3/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01328

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20/4/1

Hospital, institution, or street address where death occurred:

Crownsville State Hospital

How long in hospital or institution? 20/4/1

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Baltimore City

City or town: Baltimore, Maryland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 600 Collett Street

(If rural, give LOCATION)

2.(a) If veteran, name war: --------

3.(a) FULL NAME

HAMILTON-JENNIE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	black	married

8.(b) Name of husband or wife: William Hamilton

8.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years	Months	Days	If less than one day
47			....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Unknown

11. Industry or business: Unknown

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: Unknown

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/14/45 (month) (day) (year)

Cemetery or crematory: Hospital

Location: Crownsville

18. Funeral director: Supt

Address

19. Feb 14 1945 (Date rec'd by registrar) E. F. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 2, 1945 at 10:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 2 1944 to February 2 1945 and that I last saw her alive on February 2 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Two months
Due to: --------	
Due to: --------	
Other conditions: Mental Deficiency with Psychosis (Include pregnancy within 3 months of death)	

Major findings of operations: -------

Date of op. -----

Autopsy results: mmmmmm

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ----- Date of ----

Where did injury occur? mmmmmm (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ----

Means of injury ---- Injured at work? ----

23. SIGNATURE: Harold S. Strickroot M. D. or other

Address: Date signed

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01329

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 4 days
Hospital, Institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 months, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Charles
City or town: Marbury
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: HARRIS - EDITH V.

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	married

6.(b) Name of husband or wife: Timothy Harris
6.(c) If alive, give age: ? years
7. Birth date of deceased (mo., day, yr.): 1897

8. AGE: Years: 48 | Months: --- | Days: --- | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: ---

FATHER
12. Name: Joseph Posey
13. Birthplace: Maryland

MOTHER
14. Maiden name: Julia Jackson
15. Birthplace: Maryland

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which) Date thereof 2-16-45 (month) (day) (year)
Cemetery or crematory: Marbury
Location: Charles Co Md

18. Funeral director: Barnes & Mathews
Address: 614 4th St., SW, Washington, D.

19. 2-16 (Date rec'd by registrar) 1945 E. T. Joyce Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15 19 45 at 4:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 19 44 to Febuary 15 19 45 and that I last saw her alive on February 15 19 45

Immediate cause of death	DURATION
Bronchopneumonia	5 days
Due to: ---	
Due to: ---	
Other conditions: Organic Brain Disease	known to us 2 mos.

(Include pregnancy within 3 months of death)

Major findings of operation: ---
Date of op.: ---
Autopsy results: ---

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Albert J. Arnold M. D. or other
Address: Crownsville, Maryland Date signed 2/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01330

Reg. Dist. No. 21

1. PLACE OF DEATH: Anne Arundel

County

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Eastport

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Tyler Ave

(If rural, give LOCATION)

2.(a) If veteran, name war: World War No. 1.

3.(a) FULL NAME: William David Harrison

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: widower

6.(b) Name of husband or wife: Margaret N. Harrison

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Apr. 3, 1872

8. AGE: Years: 72 Months: 10 Days: 21 If less than one day: ..... hrs. ..... min.

9. Birthplace: Pot Pie Island, Talbot Co., Maryland (Town, county, and state)

10. Usual occupation: U. S. Navy - retired

11. Industry or business

FATHER 12. Name: Wm. J. Harrison

FATHER 13. Birthplace: Poplar Island Maryland.

MOTHER 14. Maiden name: Sally Ann Mason

MOTHER 15. Birthplace: Poplar Island, Maryland

16. Informant: Mrs. Wm Boyd.

Address: Tyler Ave., Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 26th 1945 (month) (day) (year)

Cemetery or crematory: Jehovah M.E.

Location: Jehovah Md.

18. Funeral director: J. Norman Marshall

Address: St Michaels Md.

19. Feb. 24 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby. 24 1945 at 1 P. M.

21. I CERTIFY that death occurred on the date above stated; ~~that I attended deceased from~~ Post-mortem Examination to ~~and that I last saw him alive on~~ Feby. 24 1945

Immediate cause of death	DURATION
Coronary embolus	Sudden
Due to: Coronary sclerosis	unknown
Due to: Arterio-Sclerosis	unknown
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John M. Caffey Deputy Medical Examiner M. D. or other

Address: Annapolis Md Date signed 2/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01333

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Arundel Road
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Bay Ridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Cora Catherine Harvey

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife George W. Harvey
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 4th 1875

8. AGE:	Years	Months	Days	If less than one day
	69	8	20	..... hrs. ..... min.

9. Birthplace Washington D.C.
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name William Henry Daw
13. Birthplace England
MOTHER 14. Maiden name Agatha Harvey
15. Birthplace Washington D.C.
16. Informant Mrs George W. Harvey
Address Bay Ridge A A Co Md.
17. Burial Date thereof Feby 27-1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Mt Olivet
Location Washington D.C.
18. Funeral director John W. Taylor
Address Annapolis Md
19. Feb 24 1945 Wm F Dennis
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 24 1945, at 6 a M
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 1 1944 to Feb 24 1945 and that I last saw h.. alive on Feb 23 1945

	DURATION
Immediate cause of death Myocarditis (chr) Myocardial Insufficiency	unknown
Due to Arteriosclerosis	unknown
Due to	
Other conditions Cerebral Accident	unknown

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Bail M. D. or other
Address Annapolis Md Date signed 2-24-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (43-b)

CERTIFICATE OF DEATH

Dr Johnson 01331

Reg. Dist. No. 21

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: A. A.

City or town: Mulberry Hill

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: A. A.

City or town: Mulberry Hill

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lola Hawkins

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Fem	Colored	widow

6.(b) Name of husband or wife: Richard T. Hawkins

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 21 1884

8. AGE: Years	Months	Days	If less than one day
61		24	..... hrs. ..... min.

9. Birthplace: Mulberry Hill (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: James H. Little

13. Birthplace: Md.

MOTHER 14. Maiden name: Rachel Stevens

15. Birthplace: Md

16. Informant: James Little

Address: Mulberry Hill

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar. 4 1945 (month) (day) (year)

Cemetery or crematory: Broadneck

Location: St Margarets

18. Funeral director: J. B. Johnson

Address: Annapolis

19. Mar. 3 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 28 1945, at 4.30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/23 1945, to 2/28 1945

and that I last saw h... alive on ..... 19.....

Immediate cause of death	DURATION
Cardiac Failure	
Due to: Hypertension	10 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Theodore H. Johnson M.D. M. D. or other

Address: 35 Prince George St. Date signed 3/2/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

01332

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Cedar Park
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 208 Sayler Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Carol Ann Heidler

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 9th 1944

8. AGE: Years	Months	Days	If less than one day
	2	23	hrs. min.

9. Birthplace: Annapolis Md. (Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Harry L Heidler
13. Birthplace: Annapolis Md.

MOTHER
14. Maiden name: Beatrice M. Wells
15. Birthplace: A A Co Md.

16. Informant: Harry L. Heidler
Address: 208 Sayler Ave Cedar Park

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7 Feb 4th 1945 (month) (day) (year)
Cemetery or crematory: Cedar Bluff
Location: Annapolis Md.

18. Funeral director: John M. Sayler
Address: Annapolis Md.

19. Feb 4 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 1, 1945 at 5:50 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1, 1945, to Feb 1, 1945 and that I last saw her alive on Feb 1, 1945.

Immediate cause of death	DURATION
Pneumonia (Bronchial)	
Due to (Carcinoma of Ovary with Ascites)	5 days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Albert L. Anderson M.D.
M. D. or other
Address: Annapolis Md. Date signed: 2/1/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01334

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Annapolis, Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Two days & Clinic visits

Hospital, Institution, or street address where death occurred:

U.S. Naval Hospital

How long in hospital or institution? Two days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Virginia County: King George

City or town: Dahlgren

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3. (a) FULL NAME

NEVA DILLEY HOYT

3. (b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Gordon D. Hoyt

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): 14 December 1915

8. AGE: Years	Months	Days	If less than one day
29	1	19	....hrs. ....min.

9. Birthplace: South Haven, Michigan

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER

12. Name: Carl E. Dilley

13. Birthplace: Michigan

MOTHER

14. Maiden name: Carrie E. Flory

15. Birthplace: Illinois

16. Informant: Gordon D. Hoyt

Address: Dahlgren, Virginia

17. Removal (Burial, cremation, or removal. Which?) Date thereof: 2 - 5 -45 (month) (day) (year)

Cemetery or crematory

Location: South Haven, Michigan

18. Funeral director: Ben L. Hopping

Address: 170-172 West St. Annapolis, Md.

19. Feb 5 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 3 February 1945 at 7:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11 January 1945 to 3 February 1945 and that I last saw her alive on 3 February 1945

	DURATION
Immediate cause of death: Pregnancy	8½ mo
Due to: Acute Yellow Atrophy Liver	3 days
Due to:	
Other conditions: Pregnancy was undelivered (Include pregnancy within 3 months of death)	

Major findings of operations

Date of op.

Autopsy results: Acute Yellow Atrophy of Liver

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Paul Peterson, MD M. D. or other

Address: Dispensary, USNH Date signed

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (26)

CERTIFICATE OF DEATH

01335

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A. Co

City or town Hanover

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County

City or town Hanover.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Summerfield Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6.(b) Name of husband or wife Margaret Jackson

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 15 1863

8. AGE: Years 81 | Months 11 | Days 9 | If less than one day hrs. min.

9. Birthplace A. A. Co Md (Town, county, and state)

10. Usual occupation Farmer

11. Industry or business

FATHER 12. Name Robt. W. Jackson

FATHER 13. Birthplace Md

MOTHER 14. Maiden name Maria —

MOTHER 15. Birthplace Md

16. Informant Margaret Jackson

Address Hanover Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-27-45 (month) (day) (year)

Cemetery or crematory St. Rest A. A. Co. Md

Location

18. Funeral director James A. Hayes

Address 142 W. High St

19. 2/26 19 45 A. W. Bedrick Reg. D. Registrar (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-24 19 45 at 2:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 41 to Feb 24 19 45

and that I last saw h[illegible] alive on Feb 17 19 45

Immediate cause of death	DURATION
(a) Chronic Cardiac	3 yrs
Due to, or as a consequence of (b) Decompensation	3 mo.
Due to, or as a consequence of (c) Arterial Hypertension & Mitral Insufficiency	4 yrs
Due to, or as a consequence of (d) Senility	3 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations — Date of op.

Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE B. B. Brumbaugh M. D. or other

Address Eldridge Md Date signed 2/26/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

(1) MARGIN RESERVED FOR BINDING

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

01336

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County A.A. Odenton Annearundel
City or town Near Woodwardsville Rural
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) Old Resident

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Rural Odenton Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

3. (a) FULL NAME Thornton J Jackson.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	married

6 (b) Name of husband or wife Susan Jackson
6(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) June 2 - 1872

8. AGE: Years 72 | Months 8 | Days 16 | If less than one day ____ hrs. ____ min.

9. Birthplace Anne Arundel Co Md (Town, county, and state)
10. Usual occupation R.R. Track Laborer
11. Industry or business
FATHER 12. Name Daniel Jackson
13. Birthplace Maryland
MOTHER 14. Maiden name Not Known
15. Birthplace Maryland
16. Informant Mary Jackson
Address Odenton Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/20-45 (month) (day) (year)
Cemetery or crematory Fork A.M.E. Zion Church
Location Near Woodwardsville Md
18. Funeral director Gladdon
Address Bowie Md
19. 2/19 45 E.T. Joyce (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 15 19 45, at 7:21 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 13 19 45, to Feb 17 19 45
and that I last saw h-- alive on Feb 17 19 45

Immediate cause of death Acute dilatation of Heart - Coronary Thrombosis, — DURATION
Due to Arteriosclerosis — —
Due to Hypertension 1 yr
Other conditions Bronchial Asthma —
(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE D.H. Mac Kenzie M. D. or other
Address Millersville Date signed 2-19-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01337

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a. a.

City or town: Annapolis Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: a. a.

City or town: Edgewater County Home

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Wm Jackson

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Colored	

6.(b) Name of husband or wife: none

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): unknown

8. AGE: Years: 62 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: Pasadena (Town, county, and state)

10. Usual occupation: Farm laborer

11. Industry or business:

FATHER — 12. Name: Otto Jackson

13. Birthplace: unknown

MOTHER — 14. Maiden name: Sara Carr

15. Birthplace: unknown

16. Informant: a. a. County Hospe

Address: Edgewater Md.

17. Burial, cremation, or removal. Which?: Burial Date thereof: 2/10/45 (month) (day) (year)

Cemetery or crematory: A. A County Home

Location: Edgewater Md.

18. Funeral director: F. A Twomey & Son

Address: Edgewater Md.

19. Feb 10 1945 (Date rec'd by registrar) W. Twomey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1945, at 4:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945, to Feb 10 1945, and that I last saw h. alive on Feb 9 1945

Immediate cause of death	DURATION
Chr. Myocardosis c	
Due to decompensation	2 Wks.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. J. Kloman M.D. M. D. or other

Address: 21 South Gate Ave Date signed: 2/10/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01338

Reg. Dist. No. 6

1. PLACE OF DEATH:
County Anne Aruddel
City or town Crownsville (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 yrs., 5 mos., 7 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 4 yrs., 5 mos., 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County ---
City or town Baltimore City (If outside city or town limits, write RURAL and give nearest town)
Street No. unknown (If rural, give LOCATION)
2.(a) If veteran, name war ---

3.(a) FULL NAME: JAMES - ALICE

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife ---
6.(c) If alive, give age ----- years

7. Birth date of deceased (mo., day, yr.) 1885 ?

8. AGE: Years 60 ? | Months ? | Days ? | If less than one day ---hrs. ---min.

9. Birthplace unknown (Town, county, and state)
10. Usual occupation unknown
11. Industry or business unknown
FATHER 12. Name unknown
13. Birthplace unknown
MOTHER 14. Maiden name unknown
15. Birthplace unknown
16. Informant Hospital Records
Address Crownsville, Maryland
17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb. 8, 1945 (month) (day) (year)
Cemetery or crematory Mt. Auburn Cemetery
Location Baltimore, Maryland
18. Funeral director S. W. Chase and Sons
Address 638 N. Fulton Ave Baltimore, Maryland
19. 2-7 1945 (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 5 1945 at 3:15A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 28 1940 to Feb. 5 1945 and that I last saw her alive on February 5 1945

Immediate cause of death	DURATION
Bronchial Pneumonia	2 days
Due to ---	
Due to ---	
Other conditions General Arteriosclerosis (Include pregnancy within 3 months of death)	4½ yrs.

Major findings of operations ---
Date of op. -----
Autopsy results ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ----- Date of ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ---
Means of injury --- Injured at work? ---

23. SIGNATURE Hal L. Hazlewood M. D. or other
Address Crownsville, Maryland Date signed 2/5/45

M

MARGIN RESERVED FOR BINDING

1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-C

01339

CERTIFICATE OF DEATH

Reg. Dist. No. 2

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Unknown

Hospital, institution, or street address where death occurred:
83 Washington St.

How long in hospital or institution? **********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 83 Washington St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Robert Johnson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Widower

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: **** years

7. Birth date of deceased (mo., day, yr.): April 15, 1862

8. AGE: Years	Months	Days	If less than one day
82	10		hrs. min.

9. Birthplace: West River A. A. Co. Md.
(Town, county, and state)

10. Usual occupation: Janitor

11. Industry or business: None

FATHER
12. Name: Hillary Johnson
13. Birthplace: Lothian Md. A. A. Co.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mr Hillary Johnson

Address: 62 Washington St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/ 19/45 (month) (day) (year)

Cemetery or crematory: Fowlers Cemetery

Location: Parol e Md.

18. Funeral director: Ethel L. Hicks

Address: 45 Northwest ST. Annapolis Md.

19. Feb 19, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 16, 1945, at 11:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/10 1944, to 2/16 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Carcinoma of Stomach	5 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Theodore G. Johnson Md
M. D. or other

Address: 35 Northwest State Date signed: 2/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01340

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1-18-45
Hospital, institution, or street address where death occurred:
U. S. Naval Hospital, Annapolis, Md.
How long in hospital or institution? 26 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Baltimore~~ Anne Arundel
City or town: ~~Baltimore~~ Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: ~~1007 Monroe St.~~ 413 South St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: KIRBY, John Edward

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): 12-10-88

8. AGE: Years	Months	Days	If less than one day
56	2	3	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: U. S. Navy
11. Industry or business

FATHER
12. Name: William H. Kirby
13. Birthplace: Maryland

MOTHER
14. Maiden name: A. R. Smith
15. Birthplace: Maryland

16. Informant: Miss Anna Davis
Address: 1007 N. Munroe St, Balto. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 16, 1945 (month) (day) (year)
Cemetery or crematory: National Cemetery
Location: Annapolis, Md.

18. Funeral director: John M. Taylor
Address: Annapolis, Md.

19. Feb. 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 13 February 1945 at 1230 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 18 January 1945 to 13 February 1945 and that I last saw him alive on 13 February 1945

Immediate cause of death	DURATION
Coronary occlusion	30 Min.
Due to: Arterio sclerotic heart disease with hypertension	
Due to:	
Other conditions: Fungus infection of foot	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: Coronary occlusion
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R. C. Crowell
R. C. CROWELL, Lt. Comdr (MC) USNR
M.D. or other
Address: USNH., Annapolis, Md. Date signed: 2-13-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-a)

CERTIFICATE OF DEATH

01341

Reg. Dist. No. 2 3

1. PLACE OF DEATH:
County: Anne Arundel Co
City or town: Glen Burnie.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years.
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel Co
City or town: Glen Burnie.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 205 3rd Ave. S.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3. (a) FULL NAME: Mary Elizabeth Klem

3. (b) Social Security Number: None —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White.	Married.

6.(b) Name of husband or wife: Jos. F. Klem.
6.(c) If alive, give age: 79 years
7. Birth date of deceased (mo., day, yr.): May 1, 1866

8. AGE:

Years	Months	Days	If less than one day
78	9	4	— hrs. — min.

9. Birthplace: Baltimore. Md
(Town, county, and state)
10. Usual occupation: Housewife.
11. Industry or business: at home.
FATHER 12. Name: John Kelly.
13. Birthplace: Balt. Md.
MOTHER 14. Maiden name: Isabella Beaty.
15. Birthplace: Balt. Md.
16. Informant: Jos. F. Klem.
Address: Glen Burnie Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8 - 1945 (month) (day) (year)
Cemetery or crematory: Glen Haven
Location: Ritchie Highway
18. Funeral director: Mamie E. Lysle
Address: 160 W. 10th Ave
19. Feb. 6 1945 (Date rec'd by registrar) M. Weedon Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 5 1945, at 9 15 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 5 1945
and that I last saw h— alive on Feb 4 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 wks.
Due to: Senile Arterio Sclerosis	2 years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: — Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: James S Bellingsley M.D. M. D. or other
Address: Glen Burnie Md. Date signed Feb 5 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

CERTIFICATE OF DEATH

01342

Reg. Dist. No. 25

1. PLACE OF DEATH:
County Anne Arundel
City or town Brooklyn
(If ontside city or town limits, write RURAL and give nearest town)
How leng in abeve place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD County A A Co
City or town BROOKLYN
(If outside city or town limits, write RURAL and give nearest town)
Street No. BELLE GROVE ROAD
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME JOSEPH J KOCH.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) NOV 28 1944

8. AGE: Years	Months	Days	If less than one day
	2	23	____ hrs. ____ min.

9. Birthplace BALTO. MD.
(Town, county, and state)

10. Usual occupation —

11. Industry or business

FATHER 12. Name ANTHONY KOCH.
13. Birthplace MARYLAND

MOTHER 14. Maiden name ROSE KUCHTA
15. Birthplace BALTO MD

16. Informant ANTHONY KOCH
Address BELLE GROVE ROAD

17. BURIAL Date thereof 2-23-45
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory HOLY CROSS CEM
Location A.A.Co

18. Funeral director Bernard C Harle
Address 121 E West St

19. February 22 1945 Ida M. H. Pitsom
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 20 1945 at 9 30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2.12.45. 19 to 2.20.45 19
and that I last saw him alive on 2.20.45 19

Immediate cause of death	DURATION
Broncho Pneumonia	4 Days
Due to Acute Bronchitis	4 Days
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE J. Edward Norris, M.D.
M. D. or other
Address 107 E. of West street Date signed 2.21.45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

01343

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Lake Shore, Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A. A.
City or town: Lake Shore, Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Mountain Road.
(If rural, give LOCATION)
2.(a) If veteran, name war: N

3.(a) FULL NAME: Fred Kristensen

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	M.

6.(b) Name of husband or wife: Charlotte Leach
6.(c) If alive, give age: 59 years
7. Birth data of deceased (mo., day, yr.): May - 18 - 1876

8. AGE:

Years	Months	Days	If less than one day
68	9	13	....hrs. ....min.

9. Birthplace: Norway (Town, county, and state)
10. Usual occupation: Laborer.
11. Industry or business:
FATHER 12. Name: Adolph Kristensen
13. Birthplace: Norway
MOTHER 14. Maiden name: Kathinka Georgiasen
15. Birthplace: Norway
16. Informant: Mrs. F. Kristensen (wife.)
Address: Lake Shore - Pasadena, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 7, 1945 (month) (day) (year)
Cemetery or crematory: Louden Park Cemetery
Location: Baltimore, Md.
18. Funeral director: Thomas W. Singleton
Address: Glen Burnie, Md.
19. Feb. 6 1945 (Date rec'd by registrar) M. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 5 1945 at 11.20 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19.... to ....19....
and that I last saw h....alive on ....19....

Immediate cause of death	DURATION
Sudden death due to Heart Failure	
Due to: Cerebral Hemorrhage	
Due to:	
Other conditions: —	

(Includo pregnancy within 3 months of death)

Major findings of operations: —
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Gustave A. Faubert M.D. (Attending physician or coroner) M. D. or other
Address: Glen Burnie, Md. Date signed: 2/6/45

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73d

01344

CERTIFICATE OF DEATH

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Severna

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Quarterfield Road

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days):

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Severn, Md. R.F.D. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Quarterfield Road.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Frederick Liebau

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6 (b) Name of husband or wife: Minnie Liebau

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February 13, 1882

8. AGE: Years	Months	Days	If less than one day
63	0	7	hrs. min.

9. Birthplace: Saxony Germany (Town, county, and state)

10. Usual occupation: Farmer (Retired)

11. Industry or business: Own Farm

FATHER 12. Name: Frederick Liebau

13. Birthplace: Germany

MOTHER 14. Maiden name: Tonna Peetch

15. Birthplace: Germany

18. Informant: Mrs Frederick Liebau

Address: Severn Md, R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24, 1945 (month) (day) (year)

Cemetery or crematory: Diechgraber's Cemetery

Location: Quarterfield Road A.A. Co. Md

18. Funeral director: Thomas W. Dreighton

Address: Glen Burnie Md

19. Feb 23 (Date rec'd by registrar) 19 43 Matilda R. Deale Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21, 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-18-45 19, to 2-21-45 19 45, and that I last saw him alive on 2-20-45 19

Immediate cause of death	DURATION
Chronic Myocarditis	1 Month
Due to Arteriosclerosis	6 Months
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Harry R. Moore M.D. M. D. or other

Address: Glen Burnie, Md Date signed 2/24/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01345 '21 P

Reg. Dist. No. .....

1. PLACE OF DEATH:

County A. A. Co.

City or town Ferndale

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? .....

Hospital, Institution, or street address where death occurred:

25 Ferndale Ave.

How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A. Co.

City or town Ferndale

(If outside city or town limits, write RURAL and give nearest town)

Street No. 25 Ferndale Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war .....

3. (a) FULL NAME GEORBE L. LOHRMANN

3. (b) Social Security Number 217-01-3068

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife Clara E. Lohrmann

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 9, 1880

8. AGE: Years	Months	Days	If less than one day
65	0	27	..... hrs. ..... min.

9. Birthplace Baltimore, Md. (Town, county, and state)

10. Usual occupation Retired Shipping Clerk

11. Industry or business

FATHER — 12. Name Wm. H. Lohrmann

FATHER — 13. Birthplace Md.

MOTHER — 14. Maiden name Unknown

MOTHER — 15. Birthplace "

16. Informant Mr. Edward Lohrmann

Address 25 Ferndale Ave., Ferndale, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/9/45 (month) (day) (year)

Cemetery or crematory Loudon Park Cem.

Location Balto., Md.

18. Funeral director WM. J. TICKNER & SONS

Address Balto., Md.

19. 2-8-45 (Date rec'd by registrar) A. W. Hedrick per L.C. Registrar

MEDICAL CERTIFICATION

A.

20. DATE OF DEATH Feb. 6, 1945, at 4:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18, 1945, to Feb. 6, 1945, and that I last saw h.. alive on Feb. 6, 1945

	DURATION
Immediate cause of death Cardio-Vascular Renal	1 yr.
Due to	
Due to	
Other conditions Bronchitis -	3 yr.

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Chas. L. Ball M.D.

M. D. or other

Address Linthicum Date signed Feb. 6-1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

01346

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn - Md - R.F.D
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Telegraph Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Robert M. Lowman

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: None
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 4, 1870

8. AGE: Years: 74 | Months: 8 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Anne Arundel Co. Md
(Town, county, and state)

10. Usual occupation: None

11. Industry or business: "

FATHER
12. Name: John Gustan Lowan
13. Birthplace: Anne Arundel Co. Md.

MOTHER
14. Maiden name: Mary E. Lowman
15. Birthplace: Anne Arundel Co. Md.

16. Informant: Mr Mahlan J. Hood
Address: Severn, Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 28 1945 (month) (day) (year)
Cemetery or crematory: Nichols Memorial
Location: Odenton, Md.

18. Funeral director: Thomas W. Sheridan
Address: Glen Burnie Md

19. Feb 27 1945 (Date rec'd by registrar) M.L. Death Reg. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1945, at 7.20 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb. 18-45 1945 to Feb 25 - 45 1945 and that I last saw h— alive on Feb 24-45 1945

Immediate cause of death	DURATION
Lobar Pneumonia	1 week
Due to	
Due to: Cardiac Failure	1 week
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Harry G. Lockard M. D. or other
Address: Odenton Md Date signed: Feb 27 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

01347

Reg. Dist. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Rural near Glen Burnie
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Furnace Branch Road (South of Ritchie's)

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 19 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Brooklyn, Md. R.F.D. #9 Ward No. Box 170
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: Furnace Branch Road.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

3. (a) FULL NAME: Albert Kelly Mangum

3. (b) Social Security Number: 217-12-9591

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Bertha Mattie Mangum

6(c) If alive, give age: 46 years

7. Birth date of deceased (mo., day, yr.): March 22, 1882

8. AGE: Years: 62 | Months: 10 | Days: | If less than one day: hrs. min.

9. Birthplace: Arnold, Md.
(Town, county, and state)

10. Usual occupation: Maintainence worker

11. Industry or business: Tannery.

FATHER
12. Name: Charles W. Mangum
13. Birthplace: Prince georges Co. Md.

MOTHER
14. Maiden name: Sara Elizabeth Phipps
15. Birthplace: AA Co. Md.

18. Informant: Mrs. Albert Mangum
Address: RFD - Brooklyn, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb - 23, 1945 (month) (day) (year)

Cemetery or crematory: Glen Haven Cem.

Location: Glen Burnie, Md

18. Funeral director: Thomas W. Singleton

Address: Glen Burnie, Md

19. Feb 23 (Date rec'd by registrar) 1945 Matilda R. De Alba Dep Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20, 1945, at 3:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-11-45 19 to 2-20-45 19, and that I last saw him alive on 2-20-45 19

	DURATION
Immediate cause of death: Coronary Occlusion	9 days
Due to: Arteriosclerosis	3 months
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Harry M. Moore M.D.
M. D. or other

Address: Glen Burnie Md Date signed: 2/28/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

01348

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel.
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 20 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 20 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ~~Wicomico~~ Worc.
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3. (a) FULL NAME: MARTIN - GEORGE

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	widower

6.(b) Name of husband or wife: unknown
6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1875

8. AGE: Years	Months	Days	If less than one day
70	unknown	---	-- hrs. -- min.

9. Birthplace: Maryland
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: unknown

FATHER
12. Name: ? Martin
13. Birthplace: unknown

MOTHER
14. Maiden name: Charlotte ?
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof: Feb. 28, 1945 (month) (day) (year)
Cemetery or crematory: M. E. Cemetery
Location: Snow Hill, Maryland

18. Funeral director: Dennis and Hearn
Address: Snow Hill, Maryland

19. Feb. 26 1945 (Date rec'd by registrar) E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1945 at 3:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1945 to February 24 1945 and that I last saw him alive on February 24 1945

Immediate cause of death	DURATION
General Arteriosclerosis	Known to us since 1/4/45
Due to: ---	
Due to: ---	
Other conditions: Senile Psychosis - Simple Deterioration (Include pregnancy within 3 months of death)	

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Thos. C. Pinkard M. D. or other
Address: Crownsville, Maryland Date signed: 2/2/1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01349

Reg. Diat. No. 23

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Severn Md R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 1/4 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Severn R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Quarterfield Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Dr Asher Daniel Miller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widower

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 23 1859

8. AGE: Years 85 | Months 7 | Days 3 | If less than one day: hrs. min.

9. Birthplace: North Huntingdon Pa
(Town, county, and state)

10. Usual occupation: Physician

11. Industry or business:

FATHER
12. Name: Joseph M. Miller
13. Birthplace: Hempfield Pa

MOTHER
14. Maiden name: Charlotte Wood
15. Birthplace: North Huntingdon Pa.

16. Interment: Miss Charlotte Miller
Address: Severn Md R.F.D.

17. (Burial, cremation, removal? Which?) Burial Date thereof: Feb 27 1945 (month) (day) (year)

Cemetery or crematory:
Location: Greensburg Pa

18. Funeral director: Thomas D. Singleton
Address: Glen Burnie, Md

19. Feb 27 1945 (Date rec'd by registrar) M.R. DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 26 1945, at 4.00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 10 1944 to Feb 26 1945 and that I last saw h... alive on Feb 23 1945

Immediate cause of death	DURATION
Acute Cerebral Thrombosis	
Due to	
Due to	
Other conditions Senile Enterocolitis	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. H. Lockard M. D. or other
Address: Odenton Md Date signed: Feb 27-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (38-C)

01350

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Geo. G. Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months 4 days
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 2 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Ohio County: –
City or town: Chillicothe
(If outside city or town limits, write RURAL and give nearest town)
Street No. 361 E. 2nd Street
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: Louis W. MILLER ASN: 35237649

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Betty Miller
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): September 25, 1919

8. AGE: Years	Months	Days	If less than one day
25	4	22	– hrs. – min.

8. Birthplace: Chillicothe, Ohio (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Lena (unknown) Miller
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 16, 1945 (month) (day) (year)
Cemetery or crematory: C. J. Ware, Undertaker
Location: West 2d St., Chillicothe, Ohio

18. Funeral director: Howard M. Blight
Address: 4914 Belair Road, Baltimore, Md.

19. Feb 16, 1945 (Date rec'd by registrar) W. J. LAWSON, JR., 1st Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16, 1945 at 5:15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased ~~XXX~~ on February 16, 1945 ~~XXXXXXXXXXXXXXXX~~ and that I last saw him alive on February 16, 1945

Immediate cause of death	DURATION
Renal failure	
Due to Hydro-nephrosis, Rt. Kidney	4-5 yrs.
Pyo-nephritis, Left Kidney	6 mos.
Due to Pyo-nephritis,	4 yrs.
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of –
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

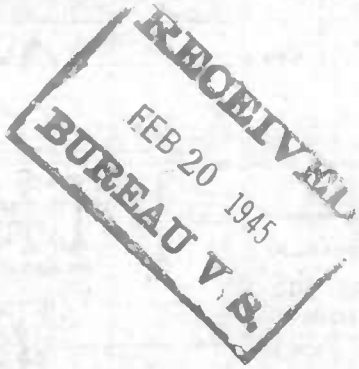
23. SIGNATURE: Thomas M. Hutchins Maj. MC
Thomas M. Hutchins, Major, M. D. or other M.C.
Address: Reg Hosp Ft Meade Md Date signed: Feb 16/45

Lt., MAC

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


RECEIVED
FEB 20 1945
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (182)

CERTIFICATE OF DEATH

01351

Reg. Dist. No. 23

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 6 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Tennessee County: Hancock

City or town: Sneedville
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Harley Lee Musick

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	S.

6.(b) Name of husband or wife: —

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): January 12 - 1945

8. AGE: Years	Months	Days	If less than one day
0	0	23	____ hrs. ____ min.

9. Birthplace: Odenton, Md
(Town, county, and state)

10. Usual occupation: None.

11. Industry or business

FATHER — 12. Name: Wasley Gilbert Musick.

FATHER — 13. Birthplace: Sneedville - Tennessee

MOTHER — 14. Maiden name: Cecil Mullins

MOTHER — 15. Birthplace: Sneedville, Tennessee.

16. Informant: Mrs. Cecil ~~Musick~~ Mullins Musick

Address: Odenton Md

17. Shipped (Burial, cremation, or removal. Which?) Date thereof: Feb 5 1945 (month) (day) (year) ✓

Cemetery or crematory:

Location: Rogersville Tenn

18. Funeral director: Thomas W Singleton

Address: Glen Burnie, Md

19. Feb 5 1945 (Date rec'd by registrar) M DeAlba Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1945 at 6:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 19__ to 19__ and that I last saw h— alive on — 19__

Immediate cause of death	DURATION
Accidental Suffocation	Sudden
(was sleeping with parents)	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of 2/4/45

Where did injury occur? Odenton (City or town) A.A. (County) Maryland (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Sleeping in bed. Injured at work? No

23. SIGNATURE: Gustave A Faubert Jnr. M.D. or other acting medical examiner

Address: Glen Burnie, Md. Date signed: 2/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


FEB 6 1945
BUREAU V.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

CERTIFICATE OF DEATH

01352

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 209 Severn Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Bessie Virginia Freeman Morgan

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	divorced

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan. 16, 1892

8. AGE: Years 53 | Months 0 | Days 18 | If less than one day ..... hrs. ..... min.

9. Birthplace Annapolis Md
(Town, county, and state)

10. Usual occupation none

11. Industry or business

FATHER
12. Name William H. Freeman
13. Birthplace A.A. Co. Md

MOTHER
14. Maiden name Sarah R. Jones
15. Birthplace A.A. Co. Md

16. Informant Elmer Freeman
Address 209 Severn Ave Eastport Md

17. Burial Date thereof Feb 7 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Cedar Bluff
Location Annapolis, Md

18. Funeral director John M. Taylor
Address Annapolis, Md.

19. Feb. 5 1945
(Date rec'd by registrar)
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1945 at 4:20 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 20 1945 to Feb 3 1945 and that I last saw h.. alive on Feb 3 1945

Immediate cause of death	DURATION
Acute Uraemia	2 Days
Due to Ca. Uterus	Several Mos.
Due to Cr. Hypertrophic Cystitis Carcinoma Deformans	1895
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Elmer Freeman M. D. or other
Address Annapolis Md Date signed 2/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01353

CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: A. A. Co.
City or town: Lothian R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, institution, or street address where death occurred:
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: A. A. Co.
City or town: Lothian R.F.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No. McSherrystown Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Peggy Lorraine Norfolk

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife: —
6.(c) If alive, give age: ... years
7. Birth date of deceased (mo., day, yr.): Dec. 2, 1944
8. AGE: Years: — Months: 2 Days: 17 If less than one day: ... hrs. ... min.
9. Birthplace: Lothian A.A. Co. Md. (Town, county, and state)
10. Usual occupation: None
11. Industry or business: —
FATHER 12. Name: Stanley Norfolk
FATHER 13. Birthplace: Dunkirk, Calvert Co. Md.
MOTHER 14. Maiden name: Nellie Mae Griffith
MOTHER 15. Birthplace: Greenock, Md.
16. Informant: Stanley Norfolk
Address: Lothian Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 20 1945 (month) (day) (year)
Cemetery or crematory: Mt. Zion
Location: at Mt. Zion
18. Funeral director: Robt. Wood
Address: Friendship, Md.
19. Feb. 19 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1945, at 6 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 18 1945 to Feb 19 1945 and that I last saw her alive on Feb 19 1945

	DURATION
Immediate cause of death: Pneumonia Bronchial	?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

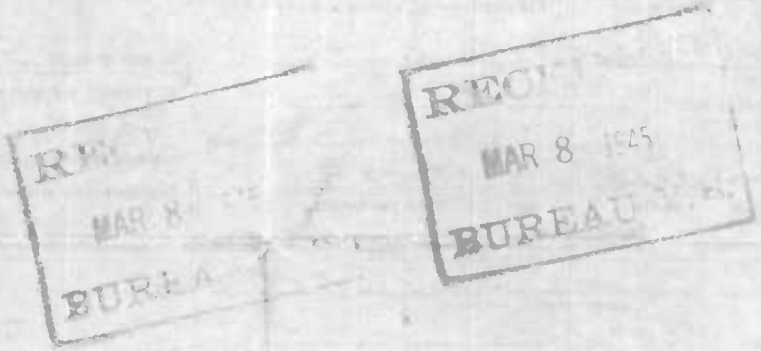
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: F. B. Frost M. D. or other
Address: Lothian Date signed: 2/14/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15


MAR 8
BUREAU
MAR 8 1945
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (109)

01354

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Geo. G. Meade
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 8 days
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: New York County: unknown
City or town: Montour Falls
(If outside city or town limits, write RURAL and give nearest town)
Street No. 440 East Main St
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: ORR, Leonard F ASN: 42113475

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Helen V. Orr
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): March 27, 1907

8. AGE: Years	Months	Days	If less than one day
37	10	17	– hrs. – min.

9. Birthplace: Bluffpoint, N. Y. (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army

FATHER
12. Name: Unknown
13. Birthplace: Unknown

MOTHER
14. Maiden name: Edith (unknown) Orr
15. Birthplace: Unknown

16. Informant: Service Record
Address: U. S. Army

17. Removal (Burial, cremation, or removal. Which?) Date thereof Feb 14 1945 (month) (day) (year)
Cemetery or crematory: J. S. Hibbard Funeral Director
Location: Elmira, N. Y.

18. Funeral director: Howard Blight
Address: 4914 Belair Road, Baltimore, Md.

19. Feb 13 1945 (Date rec'd by registrar) W J Lawson Jr. Registrar
W.J.LAWSON,JR.,1st Lt. MAC

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1945, at 11:25 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 9 1945 to Feb 12 1945 and that I last saw h. im alive on Feb 12 1945

Immediate cause of death	DURATION
Pneumonia, type undetermined	72 Hrs
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: –
Date of op.: –
Autopsy results: Confirmed as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): –
Means of injury: Injured at work? –

23. SIGNATURE: J.H. Clark Lt MC
J.H. Clark, 1st Lt., M.C. M. D. or other
Address: Reg Hosp Ft Meade Md Date signed: Feb 13/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

01355

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Wardour (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Mayland County: Anne Arundel
City or town: Wardour (If outside city or town limits, write RURAL and give nearest town)
Street No.: Norwood Road (If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Anna Thomas Owings

3.(b) Social Security Number:

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Owen P. Owings
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): June 30th 1886
8. AGE: Years: 58 Months: 8 Days: 13 If less than one day: hrs. min.
9. Birthplace: Kansas (Town, county, and state)
10. Usual occupation: None
11. Industry or business
FATHER 12. Name: Col Allen Thomas
FATHER 13. Birthplace: Baltimore Md.
MOTHER 14. Maiden name: Josephine Stafford
MOTHER 15. Birthplace: Ohio
16. Informant: Owen P. Owings
Address: Wardour R.F.D. No 1 Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feby 15th 1945 (month) (day) (year)
Cemetery or crematory: St Johns Cemetery
Location: Ellicott City Md.
18. Funeral director: Easton & Sons
Address: Ellicott City Md.
19. Feb. 14 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13 1945 at 9 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1943 to Feb 13 1945 and that I last saw h.. alive on Feb 13 1945

	DURATION
Immediate cause of death: Carcinomatosis	1 Year
Due to: Carcinoma Rt. Breast	2 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Carcinoma Breast Date of op. 1943

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Geo. P. Bond M. D. or other
Address: Annapolis Md Date signed 2-13-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01356

Reg. Dist. No. 20

1. PLACE OF DEATH:
County: Anne Arundel
City or town: ~~Stanwood~~ Stanwood
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundl
City or town: Stanwood
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Clarence Matthews Parker

3. (b) Social Security Number: 214-05-2191

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Married

6.(b) Name of husband or wife: Elizabeth Parker
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov. 7. 1907

8. AGE: Years	Months	Days	If less than one day
37	3	5	hrs. min.

9. Birthplace: Lothian A.A.Co Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business
FATHER 12. Name: Isaac Parker
13. Birthplace: Unknown
MOTHER 14. Maiden name: Young
15. Birthplace: Md Co
16. Informant: Emma Parker
Address: Stanwood Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 15-45 (month) (day) (year)
Cemetery or crematory: Adams Cem.
Location: Lothian Md
18. Funeral director: E.A. Stanley & Son
Address: Galesville Md.
19. 2/13 19 45 H.R. Clayton Deputy Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1945 at 7 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 5, 1945, to Feb 12 1945
and that I last saw h.im alive on Feb 5, 1945

Immediate cause of death	DURATION
Tuberculosis Pulmonary ?	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury. Injured at work?

23. SIGNATURE: F.B. Yeat M. D. or other
Address: Lothian Md Date signed 2/13/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01357 P

Reg. Diat. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 yrs.

Hospital, institution, or street address where death occurred: 415 W. Shipley Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. 415 W. Shipley Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary Patterson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Jan 22 - 1858

8. AGE: Years	Months	Days	If less than one day
87	1	0	...hrs. ...min.

9. Birthplace Springfield Ill. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Oleset -

13. Birthplace Conn -

MOTHER 14. Maiden name Don't Know

15. Birthplace Don't Know

16. Informant Mrs. Va Norris

Address Linthicum, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/45 (month) (day) (year)

Cemetery or crematory Loudon Pk. Cem.

Location Balto., Md.

18. Funeral director Wm. J. Tideman & Sons

Address Balto. Md.

19. 2/24 19 45 Dew. Hedrick (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22 1945 at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1940 to Feb 22 1945 and that I last saw h[illegible] alive on Feb. 22 1945

Immediate cause of death	DURATION
Cardio-Vascular Disease	2 days -
Due to	
Due to	
Other conditions Arterio-Sclerosis	10 yr.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bare Jr. M.D. M. D. or other

Address Linthicum Date signed Feb. 22 - 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

01358

CERTIFICATE OF DEATH

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County A. A.

City or town Eastport, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Anne Arundel Co.

City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 615 2nd. St.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mary C. Pitts

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow.

6.(b) Name of husband or wife George Pitts

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb 18, 1868

8. AGE: Years 78 | Months 11 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Salsbury Md.
(Town, county, and state)

10. Usual occupation domestic

11. Industry or business

FATHER 12. Name Moses Pendel

FATHER 13. Birthplace Md.

MOTHER 14. Maiden name Julia Ann

MOTHER 15. Birthplace Md.

18. Informant Moses Booth

Address 615 2nd. St. Eastport Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof ..... (month) (day) (year)

Cemetery or crematory Annapolis Neck Feb. 6, 1945

Location Annapolis Neck Md.

18. Funeral director J.B. Johnson

Address Annapolis Md.

19. Feb. 6, 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 2, 1945 at 11.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1944, to Feb 2 1945

and that I last saw h.. alive on Feb 2 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	4 days
Due to: General arteriosclerosis	
Due to:	
Other conditions: Senility	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. J. Klawans, Md
M. D. or other

Address 31 Southgate Ave Date signed 2/6/45

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01359

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Annapolis Md (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Emergency Hospt.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: St Margarets (If outside city or town limits, write RURAL and give nearest town)
Street No.: Holly Beach Farm (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Clement Poblet
3.(b) Social Security Number:

4. Sex: Male
5. Color or race: W.
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Catherine Poblet
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.): Apr 23 ~~d~~ 1868

8. AGE: Years 76 Months 8 Days 20 If less than one day ... hrs. ... min.

9. Birthplace: France (Town, county, and state)
10. Usual occupation: Gardner at Holly
11. Industry or business: Beach Farm, R.F.D. Annapolis
FATHER 12. Name: Clement Poblet
13. Birthplace: France
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Catherine Poblet
Address: R.F.D. Annapolis Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 14th 1945 (month) (day) (year)
Cemetery or crematory: St Marys Cemetery
Location: Annapolis Md
18. Funeral director: John M. Taylor
Address: Annapolis Md
19. Feb 14 1945 (Date rec'd by registrar) Wm. T. Brunch Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 12 1945, at 4 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 8th 1945, to Feb 12 1945; and that I last saw him alive on Feb 12 1945.

Cause	DURATION
Immediate cause of death: Diabetes Mellitus	Several yrs.
Due to: Gangrene left leg	Several mos.
Due to: Arterial Hypertension	Several yrs.

Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ... Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ... Injured at work?

23. SIGNATURE: Oliver Purnell M. D. or other
Address: Annapolis Md. Date signed 2/12/45

1

T

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01360

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County a a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 years

Hospital, institution, or street address where death occurred:

14 Monroe Court

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County a a

City or town Annapolis

(If outside city or town limits, write RURAL and give nearest town)

Street No. 14 Monroe Court

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Josephine T. Polyanski

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Michael J. Polyanski

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 16 - 1869

8. AGE: Years	Months	Days	If less than one day
74	2	1	..... hrs. ..... min.

9. Birthplace Poland

(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name John Kuyawa

13. Birthplace Poland

MOTHER 14. Maiden name Unknown

15. Birthplace Unknown

16. Informant Mrs. John J. Stehle

Address 14 Monroe Court Annapolis

17. Buried Date thereof Feb 20/45

(Burial, cremation, or removal) (Which?) (month) (day) (year)

Cemetery or crematory St Mary's

Location Annapolis Md

18. Funeral director B. L. Hopkins

Address Annapolis Md

19. Feb. 19 19 45 Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 17 19 45 at 5.45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 19 45 to Feb 17 19 45

and that I last saw h alive on Feb 17 19 45

Immediate cause of death	DURATION
Myocarditis + Myocardosclerosis	Unknown
Due to Hypostatic Pneumonia	Unknown
Due to Tuberculosis	
Due to	
Other conditions Arteriosclerosis	Unknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George C. Boarman M. D. or other

Address Annapolis Md Date signed 2.19.45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Dr. Burd

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

01361

CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Ft. Geo. G. Meade,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 days
Hospital, institution, or street address where death occurred:
Regional Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Delaware County: –
City or town: Frankford
(If outside city or town limits, write RURAL and give nearest town)
Street No. –
(If rural, give LOCATION)
2.(a) If veteran, name war: –

3.(a) FULL NAME: James B. POWELL ASN: 42145947

3.(b) Social Security Number: –

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: –
6.(c) If alive, give age: – years

7. Birth date of deceased (mo., day, yr.): March 22, 1926

8. AGE: Years	Months	Days	If less than one day
18	10	19	– hrs. – min.

8. Birthplace: East Landsdowne, Pa. (Town, county, and state)
10. Usual occupation: Soldier
11. Industry or business: U. S. Army
FATHER 12. Name: William E. Powell
FATHER 13. Birthplace: Unknown
MOTHER 14. Maiden name: Sadie W. (unknown) Powell
MOTHER 15. Birthplace: Unknown
16. Informant: Service Record
Address: U. S. Army
17. Removal (Burial, cremation, or removal. Which?) Date thereof: Feb 10, 1945 (month) (day) (year)
Cemetery or crematory: Frankford, Del.
Location: Howard Blight
18. Funeral director: Howard Blight
Address: 4914 Belair Road, Baltimore, Md.
19. Feb. 9, 1945 (Date rec'd by registrar) W.J. LAWSON, JR., 1st Lt., MAC Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9, 1945, at 1:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 5, 1945 to February 9, 1945 and that I last saw him alive on February 9, 1945

Immediate cause of death	DURATION
Pneumonia, Right lower lobe	36 hrs.
Due to	
Due to	
Other conditions: Scarlet Fever	

(Include pregnancy within 3 months of death)

Major findings of operation: –
Date of op.: –
Autopsy results: As above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: – Date of: –
Where did injury occur? – (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): –
Means of injury: – Injured at work? –

23. SIGNATURE: J.H. Clark 1st Lt MC
J.H. Clark, 1st Lt., M.C. M. D. or other
Address: Reg Hosp Ft Meade, Md. Date signed: Feb 9/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-2)

CERTIFICATE OF DEATH

01362

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Johnsontown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Johnsontown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) Was veteran, name war

3.(a) FULL NAME
HENSON ISIAH RICHARDS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife: Serrina Richards
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Jan. 14, 1875

8. AGE: Years	Months	Days	If less than one day
70	I	7	hrs. min.

9. Birthplace: A. A. Co., Md. (Town, county, and state)
10. Usual occupation: caretaker
11. Industry or business
FATHER 12. Name: Benj. Richards
13. Birthplace: A A Co, Md.
MOTHER 14. Maiden name: Henrietta ?
15. Birthplace: A. A. Co., Md.
16. Informant: Serrina Richards
Address: P. O. Pasadena, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-45 (month) (day) (year)
Cemetery or crematory: Magothy Cem.
Location: A. A. Co., Md.
18. Funeral director: Wm. A. Jackson
Address: 916 Penn. ave., Balto., Md.
19. 2-21 19 45 L.a. Bliss (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21 19 45 at I M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 19 42 to 2-21-45 19
and that I last saw him alive on Feb. 2 19 45
Immediate cause of death: Cerebral hæmorrhage — DURATION: 3 yrs
Due to: Arteriosclerosis — Indef.
Hypertension — " "
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: L.a. Bliss M. D.
M. D. or other
Address: Pasadena, Md. Date signed 2-21-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (172)

CERTIFICATE OF DEATH

01363

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Chesapeake Bay
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: North Carolina County: Pasquotank
City or town: Elizabeth City N. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mary Louise Roughton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	W.	S.

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct 22nd 1943

8. AGE: Years 1 | Months 3 | Days | If less than one day hrs. min.

9. Birthplace: Elizabeth City N. C. (Town, county, and state)

10. Usual occupation: none

11. Industry or business

FATHER 12. Name: Paul B. Roughton

13. Birthplace: Columbia N. C.

MOTHER 14. Maiden name: Mary R. Rawells

15. Birthplace: Dillon S. C.

16. Informant: Paul B. Roughton
Address: Elizabeth City N. C.

17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 23rd 1945 (month) (day) (year)

Cemetery or crematory: Hollywood

Location: Elizabeth City N. C.

18. Funeral director: Twiford's Funeral Home

Address: Elizabeth City N. C.

19. Feb. 23 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feby 20th 1945 at 4 30 P.M.

21. I CERTIFY that death occurred on the date above stated: ~~that I attended deceased from~~ Post Mortem 19 Examination and that I last saw ~~deceased alive~~ on Jany. 20 19 45

Immediate cause of death	DURATION
Accidental	
Due to: Drowning	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: Dec. 22, 1944
Where did injury occur? Near Bodkin Point, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) Chesapeake Bay
Means of injury: Coal Barge Sank Injured at work? —

23. SIGNATURE: John M. Cleffy Deputy Medical Examiner M. D.
Address: Annapolis Md. Date signed 2/22/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (11)

01364

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:

County: a a

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Emergency Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Millersville R. F. D.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Sarah S. Sappington

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Alderson W. Sappington

6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): July 8 1887

8. AGE: Years	Months	Days	If less than one day
57	7	15	hrs. min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Home wife

11. Industry or business

FATHER — 12. Name: Tinton Stinchcomb

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Mary P. Johnson

MOTHER — 15. Birthplace: Maryland

16. Informant: Alderson W. Sappington

Address: Millersville R F D

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 26 /45 (month) (day) (year)

Cemetery or crematory: Ladue Hills

Location: Annapolis Blvd

18. Funeral director: B. L. Hopkins

Address: Annapolis Md

19. Feb 26 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 23 19 45 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 23 19 45 to Feb 23 19 45 and that I last saw h alive on Feb 23 19 45

Immediate cause of death	DURATION
Diabetes Coma	12 hrs.
Due to: Diabetes Mellitus	Unknown
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Albert L Culverson M.D. M. D. or other

Address: Annapolis Md Date signed: 2/23/45

MARGIN RESERVED FOR BINDING. PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Evidence for change of age is shown on FILM N. G94 MAY 17 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(2)

CERTIFICATE OF DEATH

01365

Reg. Dist. No. 21

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Cedar Hurst
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Cedar Hurst
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Alice Barrick Schroder

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	white	married

6.(b) Name of husband or wife: Peter Schroder
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 9, 1878 - 1889

8. AGE: Years	Months	Days	If less than one day
55 66	5	28	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
12. FATHER — Name: John A. Barrick
13. FATHER — Birthplace: Maryland
14. MOTHER — Maiden name: Hannah Carmody
15. MOTHER — Birthplace: Ireland
16. Informant: Peter Schroder
Address: Cedar Hurst, A.A. Co. Md
17. Burial, cremation, or removal: Removal (Burial, cremation, or removal, which?) Date thereof: Feb 6 1945 (month) (day) (year)
Cemetery or crematory: Washington, D.C.
Location
18. Funeral director: Perry & Walsh
Address: H Street N.W. Washington D.C.
19. Feb. 6 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6th 19 45 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	Hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: ..... Date of op. .....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Edward Francis Walsh M. D. or other
Address: Annapolis Md Date signed: 2/6/45

BALTIMORE CITY HEALTH DEPARTMENT

CERTIFICATE OF DEATH (164a)

Registered No. 23 P

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly. MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
(a) Baltimore City, Maryland
(b) Street address PENNINGTON AVE EXTENDED
(c) Hospital or institution:
(d) Length of stay in hospital or inst. (yrs., mos., or days) 0-0-A
(e) Length of stay in Baltimore (yrs., mos., or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Md (b) County
(c) City or town Baltimore
(If outside city or town limits, write RURAL and give town)
(d) Street No. 5128 Brookwood Road
(If rural give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3 (a) FULL NAME Percy E. Shiflett

3 (b) If veteran, name war No –
3 (c) Social Security Account No. 216-05-7687

4. Sex	5. Color or race	6 (a) Single, married, widowed, or divorced.
Male	White	MARRIED

6 (b) Name of husband or wife RUTH E. SHIFLETT
6 (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 9, 1901

8. AGE: Years	Months	Days	If less than one day
43			hr. min.

9. Birthplace VA.
(Town, county, and state)
10. Usual Occupation WELDER
11. Industry or business BETH. FAIRFIELD SHIPY.

FATHER
12. Name JAMES E. SHIFLETT
13. Birthplace VA.

MOTHER
14. Maiden Name MARY E. JONES
15. Birthplace VA.

16 (a) Informant MRS. RUTH E. SHIFLETT
(b) Address 5128 BROOKWOOD ROAD

17 (a) BURIAL (Burial, cremation, or removal) (b) Date thereof 2/14/45 (month) (day) (year)
(c) Cemetery or crematory RIVER VIEW
Location WAYNESBORO, VA.

18 (a) Funeral director MILTON SCHILLING
(b) Address 3914 HANOVER STREET

19 (a) 2/14/45 (Date rec'd by registrar) FW Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-27- 1945, at M

21. I certify that I took charge of the remains described above, held an Autopsy, Inspection or Inquiry thereon and from the evidence obtained by said Autopsy, Inspection or Inquiry, find that said deceased came to his death on the day stated above, and death in my opinion resulted from: natural causes ☐, accident ☐, suicide ☑, homicide ☐, undetermined ☐ and that the causes of death were:

IMMEDIATE CAUSE OF DEATH
Asphyxiation
Due to Hanging
Other Conditions Pregnancy
(Include pregnancy within 3 months of death)

22. If an external cause was primary ☑ or contributing ☐ cause of death, fill in the following:
(a) Date of injury 2-27- at P. M.
(b) Where did injury occur? Pennington Row
(c) Did injury occur at home, on farm, industrial place, in public place? Farm While at work? No
(d) Means of injury Hanging from a rafter

23. Signature Homer L. Thuesen M.D.
Medical Examiner.
Date signed 2-27-45

VS 151

Evidence for adding of sex of deceased is shown on

FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01367

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Highland Beach R F D # 3
(If outside city or town limits, write RURAL and give nearest town) Annapolis
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: A A Co
City or town: Highland Beach
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Lowly Simms Jr.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Married

6.(b) Name of husband or wife: Florence Simms
6.(c) If alive, give age: 47 years

7. Birth date of deceased (mo., day, yr.): about 1886.

8. AGE: Years	Months	Days	If less than one day
59			hrs. min.

9. Birthplace: Harwood A.A.Co. Md
(Town, county, and state)
10. Usual occupation: Care Taker Highland Beach
11. Industry or business: A A Co Md

FATHER
12. Name: James Lowly Simms
13. Birthplace: Harwood A A Co Md

MOTHER
14. Maiden name: Mary Simms
15. Birthplace: Maryland

16. Informant: Pearl Simms
Address: 528 - 4th St Eastport Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2 8. 1945 (month) (day) (year)
Cemetery or crematory: Daniel Mar Cem -
Location: West River a.a. Co. Md.

18. Funeral director: E. H. B. Parker
Address: 47 Washington Street

19. Feb 6 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4th 1945 at 9:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	Hours
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Oliver Simms D.M.C.
M. D. or other
Address: Annapolis Md Date signed 2/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

CERTIFICATE OF DEATH

01368

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Anne Arundel Co.

City or town: Annapolis Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
79 Pleasant St.

How long in hospital or institution? ********

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)

Street No. 79 Pleasant St.
(If rural, give LOCATION)

2.(a) If veteran, name war: None

3.(a) FULL NAME: Mary Hammond Snowden

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Col.	Widow

6.(b) Name of husband or wife: **********

6.(c) If alive, give age: ****** years

7. Birth date of deceased (mo., day, yr.): February 25 1871

8. AGE: Years	Months	Days	If less than one day
74 74			..... hrs. ..... min.

9. Birthplace: Anne Arundel Co. Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: None

FATHER
12. Name: Hammond
13. Birthplace: A. A. Co. Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs Hattie Mcpherson
Address: Clay St. Annapolis Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/25/45 (month) (day) (year)
Cemetery or crematory: Breur Hill Cemetery
Location: West St. Extd.

18. Funeral director: Ethel L. Hicks
Address: 45 Northwest St. Annapolis Md.

19. Feb. 24 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 20 1945, at 10:25 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 23 1945 to Feb 20 1945 and that I last saw h.. alive on Feb 20 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	6 days
Due to: Natural Causes	1 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [illegible] M. D. or other

Address: 110 Clay Town [illegible] Date signed 2/24/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING


RECEIVED
FEB 26 1945
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01369

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Freetown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Anne Arundel
City or town: Freetown
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY ELIZABETH SPENCER

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
fem.	Negro	married

6.(b) Name of husband or wife: Edward Spencer
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Dec. 26, 1894

8. AGE: Years	Months	Days	If less than one day
50	I	21	hrs. min.

9. Birthplace: Freetown, A. A. Co., Md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business

FATHER
12. Name: Dordy
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary
15. Birthplace: Baltimore, Md.

16. Informant: Mary Juanita McDonald
Address: Freetown. P. O. Glen Burnie, Md

17. Burial
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)
Cemetery or crematory: Marley Neck Cemetery
Location: A A Co , Md

18. Funeral director: Isiah Brown
Address: 108 W Montgomery st Balto.

19. 2-16 19 45 L. A. Dent
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 16 19 45, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-7- 19 45, to 2-16 19 45
and that I last saw her alive on 2-11 19 45

Immediate cause of death	DURATION
Coronary thrombosis or embolism, probably latter	sudden
Due to: Chronic valvular heart disease, decompensated past	indefin
Due to: year	
Other conditions: Arteriosclerosis. Hyper- tension. Congenital hydroceph- alus. (Include pregnancy within 3 months of death)	" " "

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: L. A. Dent, M. D. (M. D. or other)
Address: Pasadena, Md. Date signed 2-16-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01370

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 12 yrs., 5 mos., 26 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 12 yrs., 5 mos., 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Odenton
(If outside city or town limits, write RURAL and give nearest town)
Street No.: unknown
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: SPRIGGS - SEDONIA

3.(b) Social Security Number: ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	widow

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1874

8. AGE:

Years	Months	Days	If less than one day
71	---	---	--- hrs. --- min.

9. Birthplace: Maryland
(Town, county, and state)
10. Usual occupation: Domestic
11. Industry or business: ---

FATHER
12. Name: Nick Smith
13. Birthplace: Maryland

MOTHER
14. Maiden name: Maria Dorsey
15. Birthplace: Maryland

18. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/16/45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Ralph J. Hardesty
Address:

19. Feb 26 1945 (Date rec'd by registrar) E. Joyce Loud Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 14 1945, at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 18 1932 to February 14 1945 and that I last saw her alive on February 14 1945

	DURATION
Immediate cause of death: General Paresis	Known to us since Feb. 1940
Due to: ---	
Due to: ---	
Other conditions: Mental deficiency with Psychosis (Include pregnancy within 3 months of death)	about 12½ yrs.

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: John J. Sherbow M. D. or other
Address: Crownsville, Maryland Date signed: 2/14/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

01371 R

Reg. Dist. No. 23

1. PLACE OF DEATH:

County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Life

Hospital, institution, or street address where death occurred:

Camp Meade Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County A. A.

City or town Linthicum

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 S. Camp Meade Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Arthur Thomas Stallings

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	White	married

6.(b) Name of husband or wife Alice Stallings

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) Sept. 9- 1877

8. AGE: Years	Months	Days	If less than one day
67	5	2	....hrs. ....min.

9. Birthplace A. A. Co. Md.
(Town, county, and state)

10. Usual occupation Barrel Stave salesman

11. Industry or business

FATHER 12. Name Wm Stallings

13. Birthplace A. A. Co. Md.

MOTHER 14. Maiden name Elizabeth Hare

15. Birthplace A. A. Co. Md.

16. Informant Mrs Alice Marie Stallings

Address 306 S. Camp meade Rd.

17. Burial Date thereof 2/15/45
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friendship Cem.

Location Camp Meade Rd - A.A.Co.

18. Funeral director John F Henry Inc

Address 715 Light St

19. 2-15-45 1945 A. W. Hilpirch
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 11 1945, at 11:20 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1936, to Feb. 11 1945 and that I last saw h.. alive on Feb. 11 1945

Immediate cause of death	DURATION
Cardio-Vascular Disease	3 yrs.
Due to	
Due to	
Other conditions Arteriosclerosis	5 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas. L. Bailey Jr. M.D.
M. D. or other

Address Linthicum Date signed 2-11-1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Rec'd U.S.
2/13/48

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87-2)

BC

01372

CERTIFICATE OF DEATH

Reg. Diat. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 years, 322 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 2 years, 322 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: ---------
City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)
Street No. 510 Oxford Street
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown ✓

3. (a) FULL NAME: TEW - JOHN

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	married

6.(b) Name of husband or wife: Annie Tew
6.(c) If alive, give age: unknown years

7. Birth date of deceased (mo., day, yr.): 1902

8. AGE: Years	Months	Days	If less than one day
43	unknown		--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown

FATHER
12. Name: unknown
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Buried (Burial, cremation, or removal. Which?) Date thereof 2-2-45 (month) (day) (year)
Cemetery or crematory: Mt. Calvary
Location: Anne Arundel Co.
18. Funeral director: Adolphus Halstead
Address: 9 & Ahrid Hill Ave

19. 2/26 (Date rec'd by registrar) 19 45 — E. T. Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 19 45 at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 3 19 43 to Feb. 25 19 45 and that I last saw him alive on February 25 19 45

Immediate cause of death	DURATION
Huntington's Chorea	Prior to 2/3/43
Due to: ---------	
Due to: ---------	
Other conditions: ---------	

(Include pregnancy within 3 months of death)

Major findings of operations: ---------
Date of op.: ------
Autopsy results: ---------
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -----
Where did injury occur? --------- (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ---------- Injured at work? -----

23. SIGNATURE: Harold D. Strickroder M. D. or other
Address: Crownsville, Maryland Date signed: 2/26/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01373

CERTIFICATE OF DEATH

Reg. Dist. No. 28

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: a a

City or town: Gambrills Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:
Gambrills. R F D

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: a a

City or town: Gambrills Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R F D.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Charles W. Thomas

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	married

6.(b) Name of husband or wife: Minnie M Thomas

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): Jan 9 — 1882

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
68	1	17		

9. Birthplace: Pa
(Town, county, and state)

10. Usual occupation: Landscape Gardner

11. Industry or business:

FATHER — 12. Name: William Thomas

FATHER — 13. Birthplace: Pa

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace: Unknown

16. Informant: Minnie M. Thomas

Address: Gambrills. Md. R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 1 — 45
(month) (day) (year)

Cemetery or crematory: Baldwin memorial

Location: Millersville. Md.

18. Funeral director: B I Hopkins

Address: Annapolis. Md.

19. 2/27, 1945 (Date rec'd by registrar) E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1945, at 1.50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..., 19..., to Feb 24 1945 and that I last saw h... alive on Feb 24, 1945.

Immediate cause of death	DURATION
Mitral insufficiency	
Aorta heart — failure	
Due to: Cor Valvular heart — disease	
Due to:	
Other conditions: Arthritis Chr.	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: O'D Mac Kenzie, M. D. or other

Address: Millersville Md. Date signed: 2/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01374

Reg. Dist. No. 28

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Crownsville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yrs, 5 mos, 26 days

Hospital, institution, or street address where death occurred: Crownsville State Hospital

How long in hospital or institution? 11 yrs, 5 mos, 26 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Annapolis, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: unknown (If rural, give LOCATION)

2.(a) If veteran, name war: ------

3.(a) FULL NAME: TUCKER - WILLIAM

3.(b) Social Security Number: -------

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: -------

6.(c) If alive, give age: ---

7. Birth date of deceased (mo., day, yr.): May 3, 1870 ?

8. AGE: Years	Months	Days	If less than one day
74 ?	9	1	--- hrs. -- min.

9. Birthplace: Anne Arundel County (Town, county, and state)

10. Usual occupation: Fisherman

11. Industry or business: ------

FATHER — 12. Name: William Tucker

FATHER — 13. Birthplace: Anne Arundel County

MOTHER — 14. Maiden name: Charlotte Bailey

MOTHER — 15. Birthplace: Anne Arundel County

16. Informant: Hospital Records

Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-7-45 (month) (day) (year)

Cemetery or crematory: Hospital Crownsville

Location: Dept -

18. Funeral director: -------

Address

19. Filed (Date rec'd by registrar) Feb 12 1945 E T Joyce Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1945, at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 8 1933 to Feb. 4 1945 and that I last saw him alive on February 4 1945

Immediate cause of death	DURATION
Carbuncle of Abdominal Wall	8 days
Due to: Chronic Myocarditis	unknown
Due to: -------	
Other conditions: General Arteriosclerosis (Include pregnancy within 3 months of death)	unknown

Major findings of operations: -------

Date of op.: -------

Autopsy results: -------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ------- Date of: -------

Where did injury occur? ------- (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): -------

Means of injury: ------- Injured at work? -------

23. SIGNATURE: Albert L. Snowden M. D. or other

Address: Crownsville, Maryland Date signed: 2/4/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01375

Reg. Diat. No. 23

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Anne Arundel

City or town: Stoney Run; Hanover Md, R.F.D.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Stoney Run Road

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days): 22 years.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Anne Arundel

City or town: Stoney Run; Hanover Md R.F.D. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Stoney Run Road Near P.R.R. Sta.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Carrie Marszalek Turner

3. (b) Social Security Number: NONE.

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife: John Wm. Turner

Deceased — 6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Feb. 2, 1889

8. AGE:

Years	Months	Days	If less than one day
56	0	18	____ hrs. ____ min.

9. Birthplace: Poland.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: —

FATHER
12. Name: Joseph Marszalek
13. Birthplace: Poland

MOTHER
14. Maiden name: —
15. Birthplace: Poland

16. Informant: Mrs. Anna Hubriel
Address: Hanover, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 24, 1945 (month) (day) (year)

Cemetery or crematory: Holy Rosary Cemetery

Location: Baltimore

18. Funeral director: Thomas W. Daughton

Address: Glen Burnie, Md.

19. Feb 23 1945 (Date rec'd by registrar) Matilda R. De Alba Dep. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 20, 1945, at 8:05 PM.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1942 19__ to 2-20-45 19__; and that I last saw h[illegible] alive on 2-20-45 19__.

Immediate cause of death: Broncho Pneumonia — DURATION: 2 wks.

Due to: —

Due to: —

Other conditions: Pulmonary Tuberculosis (Chronic Arrested)
(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Harry J. Moore M. D. or other

Address: Glen Burnie, Md. Date signed: 2/20/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (H-2)

01376

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Pasadena
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 years.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Pasadena, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Emory O. Hasner.

3.(b) Social Security Number 057103251

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married.

B.(b) Name of husband or wife Lucie KEILHOTZ.
6.(c) If alive, give age 50 years
7. Birth date of deceased (mo., day, yr.) June 15 - 1893

8. AGE:

Years	Months	Days	If less than one day
52	7	19	hrs. min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation Engineer.
11. Industry or business Montgomery Ward.
FATHER 12. Name Wilhelm Hasner
13. Birthplace England.
MOTHER 14. Maiden name Irene Pickett
15. Birthplace Maryland.
16. Informant Mrs. Lucie Hasner (wife)
Address Pasadena, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/7/44 (month) (day) (year)
Cemetery or crematory Loudon Park
Location Frederick Road
18. Funeral director John F. Denny, Inc.
Address 715 Light St.
19. 2/6 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 19 45 at 8:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 15 19 44, to February 3 19 45 and that I last saw him alive on 1/20/45 19

Immediate cause of death	DURATION
Heart failure	
Due to Acute Interstitial nephritis.	15 days
Due to Carcinoma of transverse Colon	7 4 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation Malignancy of transverse Colon. Date of op. 1/16/44 1/27/44

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Gustave A. Carlson M.D. M. D. or other
Address Glen Burnie Md. Date signed 2/4/45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

01377

Reg. Diat. No. 21

1. PLACE OF DEATH:
County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Anne Arundel
City or town Eastport
(If outside city or town limits, write RURAL and give nearest town)
Street No. 320 Sixth St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Oscar E. Wheeler

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Annie E. Wheeler

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug. 24, 1877

8. AGE: Years 67 | Months 5 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace A.A.Co. Maryland (Town, county, and state)

10. Usual occupation Fisherman

11. Industry or business

FATHER
12. Name Alfred Wheeler
13. Birthplace Maryland

MOTHER
14. Maiden name Annie Holland
15. Birthplace Maryland

16. Informant Mrs. Annie Wheeler
Address 320 6th St. Eastport, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 9 1945 (month) (day) (year)
Cemetery or crematory Cedar Bldg
Location Annapolis Md.

18. Funeral director John M. Taylor
Address Annapolis Md.

19. Feb. 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 6 1945, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 5 1945, to Feb 6 1945
and that I last saw h... alive on Feb 6 1945

Immediate cause of death	DURATION
Coronary Thrombosis	2 days
Myocardosis acute	2 days
Due to	
Due to	
Other conditions Arteriosclerosis.	unknown

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE George C Basil M. D. or other
Address Annapolis Md. Date signed 2-7-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01378

CERTIFICATE OF DEATH

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 19 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 3 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Anne Arundel
City or town: Annapolis
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 8 Pleasant Court
(If rural, give LOCATION)
2.(a) If veteran, name war: unknown

3. (a) FULL NAME: WILSON - THEODORE M.

3. (b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	black	single

6.(b) Name of husband or wife: ---------

6.(c) If alive, give age: ---- years

7. Birth date of deceased (mo., day, yr.): 1917

8. AGE: Years	Months	Days	If less than one day
28	?	?	--- hrs. --- min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: unknown
11. Industry or business: unknown
12. FATHER — Name: unknown
13. FATHER — Birthplace: unknown
14. MOTHER — Maiden name: Annie Wittenhall
15. MOTHER — Birthplace: unknown
16. Informant: Hospital Records
Address: Crownsville, Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13, 1945 (month) (day) (year)
Cemetery or crematory: Brewer Hill Cemetery
Location: Annapolis, Maryland
18. Funeral director: J. B. Johnson
Address: Annapolis, Maryland
19. Feb. 13 19 45 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 9 19 45, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 20 19 44, to Feb. 9 19 45; and that I last saw him alive on February 9 19 45

Immediate cause of death: General Paresis — DURATION: Known to us since 11/2/44
Due to: ---------
Due to: ---------
Other conditions: ---------
(Include pregnancy within 3 months of death)
Major findings of operations: ----------
Date of op.: -----
Autopsy results: ----------

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ------- Date of: -------
Where did injury occur? ---------
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -------
Means of injury: ---------- Injured at work? -------

23. SIGNATURE: Albert V. Winterode M. D. or other
Address: Crownsville, Maryland Date signed: 2/9/45

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01379

Reg. Dist. No. 28

1. PLACE OF DEATH:
County: Anne Arundel
City or town: Crownsville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 4 days
Hospital, institution, or street address where death occurred:
Crownsville State Hospital
How long in hospital or institution? 1 month, 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Dorchester
City or town: Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 3 Edgewood Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war: ---

3.(a) FULL NAME: WOOLFORD - EUNICE

3.(b) Social Security Number: unknown

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	black	single

6.(b) Name of husband or wife: ---
6.(c) If alive, give age: --- years

7. Birth date of deceased (mo., day, yr.): 1922

8. AGE: Years: 23 | Months: --- | Days: --- | If less than one day: ---hrs. ---min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Factory Laborer
11. Industry or business: ---

FATHER
12. Name: Joseph Woolford
13. Birthplace: unknown

MOTHER
14. Maiden name: unknown
15. Birthplace: unknown

16. Informant: Hospital Records
Address: Crownsville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 3-5-45 (month) (day) (year)
Cemetery or crematory: Hospital
Location: Crownsville Md

18. Funeral director: Supt.
Address: Crownsville

19. Mar 5 1945 (Date rec'd by registrar) E. Joyce Lowe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 21 19 45 at 10:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 17 19 45 to Feb. 21 19 45 and that I last saw her alive on February 21 19 45

Immediate cause of death	DURATION
General Paresis	Known to us since 2/2/45
Due to: ---	
Due to: ---	
Other conditions: ---	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.: ---
Autopsy results: ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: --- Date of: ---
Where did injury occur? --- (City or town) --- (County) --- (State)
Injured at home, farm, industry, public place (where?): ---
Means of injury: --- Injured at work? ---

23. SIGNATURE: Abel J. Armitrood M. D. or other
Address: Crownsville, Maryland Date signed: 2/21/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING